SENATE HEALTH
COMMITTEE ANALYSIS
Senator Sheila J. Kuehl, Chair

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AUTHOR:	**Nunez**	**B**
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CONSULTANT: Hansel/Dunstan/Patterson/Moreno/Park

FOR VOTE ONLY

SUBJECT

Health insurance reform

SUMMARY

Requires all California residents to carry a minimum level of health insurance coverage for themselves as well as for their dependents. Establishes a state purchasing pool through which qualifying individuals would be allowed to obtain subsidized or unsubsidized health care coverage. Expands eligibility for the Medi-Cal and Healthy Families programs, and increases Medi-Cal provider rates for hospitals and physician services. Requires health plans and insurers to offer and renew, on a guaranteed basis, individual coverage in five designated coverage categories, regardless of the age, health status, or claims experience of applicants, and establishes new modified community rating rules for the pricing of individual coverage. Contains provisions intended to reduce or offset a portion of the costs of health coverage as well as several new programs and initiatives related to prevention and promotion of health and wellness. Expresses intent that financing for the bill's provisions shall come from a variety of sources, including federal funds related to Medi-Cal and Healthy Families program expansions, fees from employers, revenues from counties, fees paid by acute care hospitals, premium payments from individuals, and funds from a new tobacco tax. Some of these financing measures would be contained in a proposed ballot initiative. Makes implementation of its provisions contingent upon a finding by the Director of Finance that sufficient state resources are available to implement the provisions.

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CHANGES TO EXISTING LAW

I. Mandate to maintain minimum creditable coverage – sections of bill: 11, 12, 54

A. Requirement to enroll in and maintain minimum creditable coverage

Existing law does not require residents to maintain a minimum level of health insurance coverage. This bill would, beginning on July 1, 2010, require all residents and their dependents to enroll in and maintain minimum creditable coverage. The bill would direct the Managed Risk Medical Insurance Board (MRMIB) to establish, by regulation, the definition of minimum creditable coverage on or before March 1, 2009, as well as standards for minimum creditable coverage that, at a minimum, apply to the individual insurance market. The bill would require minimum creditable coverage to include physician, hospital, and preventive services as well as any coverage requirements under existing law. In determining the standards for minimum creditable coverage, including the scope of services, deductibles, co-payment requirements, and coverage of services outside of the deductible, the MRMIB would be required to consider the degree to which minimum creditable coverage protects residents from catastrophic medical costs, the extent to which any cost sharing requirements would deter appropriate and timely care, including whether preventive services should be required to be provided without any deductible, the affordability of coverage, the importance of periodic health evaluations and preventive care, and other factors.

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Compliance with the mandate would not be required until several provisions of the bill were implemented, including establishment by regulation of a definition by MRMIB of minimum creditable coverage and a process for ensuring that residents obtain minimum coverage, and implementation of the bill's coverage expansions, purchasing pool provisions, and tax credit provisions. In addition, implementation of the requirement to enroll in and maintain minimum creditable coverage, as well as all other provisions of the bill, would be contingent on a finding being made by the Director of Finance that sufficient financial resources necessary to implement the bill's provisions are, or will be, available, as specified.

B. Exemptions

The bill would exempt individuals with income at or below 250 percent of the federal poverty level (FPL) from the requirement to maintain minimum creditable coverage if premium costs exceed five percent of that individual's family income. Residents who have been in California for six months or less and who are, on that basis, not eligible for guaranteed issue of health insurance coverage under other provisions of the bill would also be exempted.

Additionally, by January 1, 2010, MRMIB would be required to adopt regulations to establish and review affordability and hardship standards, by which individuals could apply for a temporary or continuing exemption from the mandate. In establishing the affordability and hardship standards, MRMIB would be required to consider a number of factors, including the total out-of-pocket costs for minimum coverage, the cost-sharing levels as a percentage of an individual's income, as specified, the impact of premium costs on the ability of an individual to afford other basic life necessities, and the effect of the exemption criteria on premium levels for all health care coverage enrollees. MRMIB would be required to report to the Legislature and the Department of Managed Health Care (DMHC) on the number of individuals who are exempted from the coverage mandate.

C. Enforcement

This bill would require MRMIB to establish by regulation methods to ensure that uninsured individuals obtain the minimum health care coverage. This bill would require MRMIB to pay the cost of health care coverage on behalf of an individual who has been uninsured for at least 62 days, and to establish methods by which funds advanced for coverage may be recouped by the state from individuals for whom coverage is purchased.

This bill would authorize MRMIB to enter into an agreement with the Franchise Tax Board (FTB) to use its civil authority and procedures, in compliance with notice and other due process requirements imposed by law, to collect funds owed to the state that were advanced on behalf of uninsured individuals. According to the Senate Revenue and Taxation Committee, all existing practices utilized by the FTB to collect funds owed to the state could be used to recoup funds advanced to pay for coverage for uninsured individuals, including the ability to assess interest and monetary penalties, offset taxpayer refunds, garnish wages, file judgments, and impose tax liens.

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The bill would require that, to the extent possible, existing reporting processes employed throughout the state to report on the employment and tax status of individuals and other existing mechanisms are to be used to implement the enforcement of the individual mandate. Relevant state agencies would be required to cooperate with MRMIB and other responsible entities in undertaking these activities and implementing these provisions of this bill. Before entering into any agreements with other agencies or departments, MRMIB would be required to report to the Legislature on the methods it would use to identify individuals with and without coverage, how individuals would be notified of the availability of coverage and timeframe to enroll, actions to enroll the uninsured, and actions to be taken if individuals do not enroll. Implementation of these enforcement provisions would also be contingent on a budget appropriation.

Plans and insurers could also impose a preexisting condition exclusion period of up to 12 months on coverage they offer to any person who fails to comply with the mandate for more than 62 days. Additionally, upon their enrollment into coverage, they could only enroll in the lowest coverage choice category.

MRMIB would also be required to establish and maintain a statewide education and awareness program to inform California residents of their obligation under the individual mandate, identify and implement methods and strategies to establish multiple entry points and opportunities for enrollment in public or private coverage, and establish methods by which individuals who have not obtained health care coverage are informed of the methods available to obtain affordable coverage through public programs, the statewide purchasing pool established under this bill to be administered by MRMIB, and commercial coverage. Additionally, the bill would permit school districts, on or after January 1, 2010, to provide an information sheet regarding health insurance requirements to specified parents and guardians based on a template that is developed by the California Department of Education, the Department of Health Care Services (DHCS), and MRMIB.

Comments and issues

1. Mandate not contingent on enactment of proposed initiative. While implementation of the requirement to enroll in and maintain minimum creditable coverage is contingent on a finding being made by the Director of Finance that financial resources necessary to implement the bill's provisions are available, it is not contingent on enactment of the proposed financing initiative per se (discussed below). A recommended amendment would be to make it clear in the bill that implementation of the mandate and its enforcement is contingent on passage of the initiative.

Suggested language:
On page 19 of the bill, lines 18 – 39, amend as follows:

8899.50. (a) On and after July 1, 2010, every California resident shall be enrolled in and maintain at least minimum creditable coverage, as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code, unless otherwise exempt pursuant to subdivision (d).

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(b) On and after July 1, 2010, a subscriber shall obtain and maintain at least minimum creditable coverage, as defined by the Managed Risk Medical Insurance Board, for any person who qualifies as his or her dependent. For purposes of this chapter, the term "dependent" means the spouse, registered domestic partner, minor child of the subscriber, or a child 18 years of age and over who is dependent on the subscriber, as defined by the Managed Risk Medical Insurance Board.

(c) Notwithstanding subdivisions (a) and (b), compliance with those subdivisions shall not be required until Sections 12739.50, 12739.51, and 12699.211.01 of the Insurance Code, Section 17052.30 of the Revenue and Taxation Code, and Sections 14005.301 and 14005.305 of the Welfare and Institutions Code are implemented, and only so long as these sections remain operative, and the Managed Risk Medical Insurance Board has defined by regulation the minimum creditable coverage that will satisfy the requirements of this section.

(d) Compliance with subdivisions (a) and (b) shall not be required if an initiative measure containing funding for the Act is not approved by the voters.

2. Scope of minimum creditable coverage unclear. Under the language of the bill, it is unclear whether benefits such as prescription drug coverage and maternity coverage would be included in the definition of minimum creditable coverage, or that preventive services would be required to be provided outside of any deductible that otherwise applies, or that preventive services would include all preventive services, including detection and management of chronic conditions. It is also not clear what maximum level of deductibles and other cost sharing would be permitted, or whether the definition would include a limit on out-of-pocket costs. As drafted, these determinations would be made by MRMIB.

3. Application of minimum creditable coverage to group market unclear. It is not clear how the definition of minimum creditable coverage that MRMIB develops would apply to group coverage or how MRMIB would determine what types of group coverage satisfy the mandate. The bill states only that the definition of minimum creditable coverage that MRMIB develops is intended to apply, at a minimum, to individual coverage. Without action by MRMIB to define what types of group coverage satisfy the mandate, most residents would not be able to certify, if asked, that their coverage satisfies the minimum requirements. If MRMIB were to deem categories of coverage as meeting the minimum creditable coverage standard, such as all group coverage or multiple employer welfare arrangements, it could have the effect of undermining the standard for large numbers of residents.

4. Deductibles and other cost sharing not counted in affordability exemption. The affordability exemption in the bill for residents with incomes below 250 percent of the FPL does not take into consideration the costs of deductibles or other cost sharing. For many residents, even many with incomes below 250 percent of the FPL, the premium costs associated with minimum coverage, if it is high deductible coverage, could meet the requirements of costing below five percent of their incomes, which would make those residents subject to the mandate, even where total cost of coverage, including the high deductibles, exceed five percent of income.

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5. Process to determine affordability exemptions unclear. It is unclear in the bill how MRMIB would determine additional affordability exemptions, beyond those provided in the bill. It is not clear if MRMIB would grant additional blanket exemptions based on a broader consideration of out-of-pocket costs, or limit the additional exemptions to case-by-case exemptions. Considering and hearing individual requests for hardship exemptions is likely to require significant resources and administrative expenses for MRMIB.

6. Enforcing mandate could be difficult. Based on the experience in Massachusetts, which has a mandate to maintain minimum coverage similar to that proposed in ABX1 1, enforcing this type of mandate could be difficult. According to the information provided by the Commonwealth Connector, which is charged with implementing many provisions of Massachusetts' law, only 50 – 75 percent of the uninsured population has enrolled in some form of coverage as of January, 2008. It appears, based on early analysis, that compliance among persons who are not eligible for subsidies has been weakest. The penalties for noncompliance in the first year are relatively weak in Massachusetts (loss of a personal tax exemption equal to $219), and will increase in the second year of implementation to half of the cost of the lowest cost plan providing minimum coverage, which program administrators hope will encourage greater compliance. The author and administration believe the system proposed by ABX1 1 will produce greater compliance by automatically enrolling persons who are identified as not having minimum coverage into such coverage and recouping the costs from them.

7. Identifying persons not complying, accurately enrolling them into coverage, and recouping costs could also be difficult. It is not clear how MRMIB would determine who is not complying with the mandate to maintain minimum creditable coverage. The author indicates that persons lacking minimum coverage would be identified at the point they seek medical services or request state services, but determining whether they are, in fact, subject to the mandate, would be a difficult undertaking, given that they may be exempt based on income, have sub-minimum coverage that qualifies under the grandfathering provisions for such coverage, or have other coverage that they don't know about at the time they seek services. Under the bill, MRMIB would describe this process in a report to the Legislature by March, 2010.

8. Scope of FTB enforcement authority. According to the Senate Revenue and Taxation Committee staff, the bill would allow FTB to use all of its enforcement powers to recoup amounts owed to the state by persons who are determined not to have minimum coverage and are automatically enrolled in it, including the ability to place liens on property and garnish wages. The author has indicated that the Legislature can curtail this practice, if necessary, in the future**.** Regardless, recouping costs of coverage from people who are identified as lacking minimum coverage and automatically enrolled in it could be very difficult, reducing the amount the state is actually able to recover and adding costs to the plan.

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II. Purchasing pool, coverage expansions, and proposed tax credits - sections of bill: 31.1-31.6, 43, 48-51, 53, 55-56, 57.1-57.7, 58.5-59, 61-70, 73, 84

A. Medi-Cal and Healthy Families eligibility changes

California provides health coverage, for certain individuals and families who qualify, through Medi-Cal and Healthy Families. Medi-Cal is administered by the DHCS. Healthy Families provides low-cost health, dental, and vision coverage to children who are uninsured and do not qualify for full scope Medi-Cal without a share of cost. Current law extends Medi-Cal eligibility to children in families with incomes up to 100 or 133 percent of the FPL, depending on their age, and working families with incomes up to approximately 100 percent of the FPL under the Medi-Cal program. Some very low income 19- and 20-year-olds may be eligible for Medi-Cal under the medically indigent program. Parents and other caretaker relatives are eligible for Medi-Cal under several different eligibility categories with varying income ceilings. Generally, persons do not pay premiums to be enrolled in Medi-Cal and may pay nominal co-payments for services.

MRMIB administers Healthy Families and the majority of funding comes from the federal State Children's Health Insurance Program (SCHIP). Healthy Families eligibility is for those children in families with income that is greater than the eligibility requirement for Medi-Cal but not more than 250 percent of the FPL. Healthy Families requires families to pay monthly premiums and larger co-payments.

In addition, under federal law, SCHIP and Medicaid programs are limited to U.S. citizens and "qualified aliens," a selected group of legal immigrants. Another important provision of federal law is the federal Deficit Reduction Act (DRA) which authorizes states to use benchmark plans, which allow the state more flexibility in determining benefits and cost sharing.

ABX1 1 would make a number of changes in eligibility for the Medi-Cal and Healthy Families programs:

- Effective July 1, 2009, increase the income limit for Healthy Families eligibility for children in families with incomes between 250 and 300 percent of the FPL ($51,500 for a family of three). This start date is earlier than all other provisions of the act. ABX1 1 would require these newly eligible families to pay higher monthly premiums for covering their children, $25 per child with a maximum of $75 per family. The bill would also expand eligibility for the Healthy Families and Medi-Cal programs to children without regard to their immigration status who otherwise meet program requirements.

- Expand Medi-Cal eligibility for 19- and 20-year-olds and parents and caretakers with incomes up to 250 percent or less of the FPL. For these expansions to occur, DHCS

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must obtain federal approval. Coverage would be from the pool by a Cal-CHIPP Healthy Families plan, which would be a benchmark plan.

- Make low-income childless adults eligible for public programs. Those in families with incomes of 100 percent or less of the FPL would receive their benefits through a Medi-Cal plan designed by DHCS that is equivalent to the Cal-CHIPP Healthy Families plan but would face limitations that don't apply to other Medi-Cal recipients, including no use of income disregards, loss of certain procedural rights, and no right to retroactive coverage. Those with family incomes between 100 and 250 percent of the FPL would receive coverage through a Cal-CHIPP Healthy Families benchmark plan through the purchasing pool. Eligibility would be limited to those who are not offered employer-sponsored health care coverage or are not enrolled in or eligible for health care programs or services which the employer claims for purposes of the pay or play requirement. The bill would make this expansion contingent on counties providing a share of the costs.

- Coverage for the childless adult in families with incomes of 100 percent or less of the FPL could be offered through a "local coverage option" (LCO) in those counties with public hospitals and only at the county's choice. The LCO would have to be a Knox-Keene licensed health plan and would be designed to support the county's public hospital.

  The county could administer the LCO itself or choose the local initiative (LI) or county organized health system (COHS), which are health plans that work with the county to provide Medi-Cal managed care. The LCO would be required to provide services through the designated public hospital, its affiliated public providers and primary care clinics, and could be required to use other providers to meet Knox-Keene requirements. The entity which administers the LCO would enter into a contract and negotiate a capitated rate with DHCS and could share risk with the state. Implementation would be contingent on counties paying a share of cost for expanded Medi-Cal eligibility. To assist the LCO in gaining viability, it would be the exclusive provider for four years and, after that, it would be the default plan. DHCS would evaluate the LCOs after three years, and if the LCO is not meeting performance standards, it could lose its exclusivity.

- These expansions would be effective on the later of July 1, 2010, or on the date that MRMIB implements the provisions of the Insurance Code regarding, among other provisions, taking steps to ease enrollment into insurance, including the public programs, to help prepare people for the mandate. For the public program, educational portion, MRMIB is required to consult with DHCS and identify multiple entry points for enrollment in public coverage. MRMIB is also directed to work with the large number of interested parties, including consumer groups, health plans, government agencies, and other stakeholders. The bill requires MRMIB to identify point of service enrollment for public and private insurance and for the public programs to maintain best practices for streamlined eligibility.

B. Enrollment streamlining provisions

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ABX1 1 contains provisions to ease enrollment in Medi-Cal and Healthy Families that would take effect July 1, 2010. Under existing law, certain Medi-Cal beneficiaries must undergo a semi-annual reporting process to remain eligible for Medi-Cal. In lieu of this requirement, the proposal would require a semi-annual address verification report, to verify that enrollees can be contacted and to ensure accurate payments to Medi-Cal managed care plans. Medi-Cal eligibility would be terminated if letters and phone contact do not yield the necessary information from the beneficiary. Children, pregnant women, seniors, and persons with disabilities would be exempt from this provision.

ABX1 1 would streamline the "deprivation test," which requires, as a condition of eligibility, that a child be deprived of parental support, due to the fact that a parent is absent, working, deceased, or unemployed. The proposal would also eliminate the requirement that working families document their assets as a condition of becoming eligible for Medi-Cal, and also provides that an asset test is not required for eligibility for the program expansions in this proposal. These changes would facilitate the enrollment of beneficiaries at the place they receive services.

The proposal also includes language extending to enrollees in programs administered by MRMIB the same confidentiality protections which now apply to the Medi-Cal program.

Comments on coverage expansion and streamlining provisions

1. Childless adults who have access to employer coverage excluded. The bill excludes childless adults with incomes below 250 percent of FPL, who have access to employer coverage of any kind for which the employer makes a contribution, from eligibility under the coverage expansion for childless adults. This could exclude employees whose employers make even nominal contributions towards their coverage from eligibility.

2. Children's health advocates are concerned that given the timetable in the bill, many children will lose their current coverage. These children are enrolled in children's health initiatives (CHIs), local programs that provide coverage to children currently ineligible under state law. CHIs have insured 84,000 children through a patchwork of funding. Advocates argue the local CHIs cannot be sustained in the time before ABX1 1 is implemented and that $50 million is needed in FY 08-09 to prevent these children from losing their coverage. The funding initiative submitted to the Attorney General to fund ABX1 1 would allow MRMIB**,** on or before January 1, 2009 to be advanced an amount no greater than $25 million, which in turn would be granted to the CHIs.

3. Proposed budget cuts affecting eligibility determinations conflict with bill. The Governor's budget proposes to reimpose quarterly status reporting, under which Medi-Cal beneficiaries would be required to report quarterly on their eligibility status or lose their eligibility. This is expected to both increase administrative requirements and reduce enrollment, resulting in $200 million in combined state and federal savings in the budget year**.** In contrast, ABX1 1 contains provisions that ease administrative requirements to make enrolling in, and staying enrolled in, Medi-Cal easier. If the proposed cuts were

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implemented, additional funds would be needed to restore them in order to implement the provisions of ABX1 1, or these provisions of the bill would need to be revised.

4. The Governor's proposed budget would likely increase the costs for counties. The previously discussed increase in administrative requirements and the accompanying reduction in Medi-Cal enrollment**,** if enacted**,** are likely to lead to more of the medically indigent seeking care from counties. In addition, the proposed budget includes reductions in Medi-Cal's dental program which could increase the county's costs for providing services to the medically indigent. The Medi-Cal provider rate cuts may lead to more health care providers exiting the program, which could increase demand for services at safety net providers, including the public hospitals. It is not clear that potential impacts to counties have been taken into account in determining the amount of funds counties must provide for the state under the proposed initiative.

C. State purchasing pool

Establishment and operation of purchasing pool. The bill would establish the California Cooperative Health Insurance Program (Cal-CHIPP), a statewide purchasing pool administered by MRMIB, which would offer, by July 1, 2010, subsidized and unsubsidized coverage to eligible individuals and their dependents. MRMIB would have broad authority to administer Cal-CHIPP, including authority to determine eligibility and enrollment and disenrollment criteria, premium schedules, participating plan requirements and rates, benefit designs, and co-payments.

Eligibility to enroll in Cal-CHIPP would be extended to residents who meet one of the following criteria: are employees or dependents of an employer who has elected to pay his or her full contribution into the Fund, are eligible for one of the coverage expansions pertaining to parent and caretaker relatives or childless adults, are employees or dependents who pay the full cost of health coverage through a Section 125 plan in which the employer designates Cal-CHIPP in the cafeteria plan, or who have incomes between 250 and 400 percent of the FPL and are not eligible to receive coverage through an employer or eligible for other health care programs or services an employer pays for that qualify as health care expenditures for purposes of the pay or play election.

The pool would offer both subsidized and unsubsidized plans to enrollees. Individuals age 19 or older who meet federal citizenship or legal residency requirements, are ineligible for standard Medi-Cal, but are eligible under one of the coverage expansions described previously, and have an annual income greater than 100 percent of the FPL, but less than 250 percent of the FPL, would be eligible to enroll in a Cal-CHIPP Healthy Families Plan. These plans would be required to meet Knox-Keene Act requirements and also include prescription drug benefits, which at a minimum would include coverage for generic drugs, and brand name drugs when a generic is unavailable or the patient requires brand name drugs, and include enrollee cost-sharing levels that promote prevention and health maintenance, including physician visits, diagnostic laboratory services, and medications to manage chronic diseases. Enrollees who are childless adults would additionally be required not to have access to employer-sponsored health coverage or be

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eligible for health care programs or services an employer pays for that count as health care expenditures for purposes of the pay or play election.

Individuals eligible for a Cal-CHIPP plan with annual family incomes equal to or below 150 percent of the FPL ($15,300 for an individual) would not pay any premiums or out-of-pocket costs for the coverage. Premium costs for individuals with family incomes between 150 percent and 250 percent of the FPL could not exceed five percent of family income, net of allowable income deductions. Deductibles and co-payments are not included in this calculus.

When determining deductibles and co-payments for subsidized coverage for Cal-CHIPP plans, MRMIB would be required to determine whether related costs would deter an enrollee from obtaining appropriate affordable and timely care, and to consider the impact of these costs on an enrollee's ability to afford health care services.

For individuals who are not eligible for a Cal-CHIPP plan**,** i.e. with incomes greater than 250 percent of the FPL, MRMIB would be required to offer at least one product that meets minimum creditable coverage, and one product each from coverage choice category three and five. MRMIB would be required to establish premiums for unsubsidized coverage at a level commensurate with the full premium cost of the coverage chosen by the employee. For qualified individuals, these premium costs could be partially or wholly offset by the value of a proposed health care tax credit, which is discussed below. Additionally, MRMIB would be required to provide a contribution equal to 20 percent of the premium of a tier 1 product in the pool towards the cost of coverage for employees with incomes above 250 percent of the FPL whose employers have elected to pay into the Fund, if the employee is not enrolled in or eligible for any coverage or services for which the employer is making health care contributions for purposes of the pay or play requirement (described under Financing section below)**.**

Proposed tax credit. The bill would establish an income tax credit, beginning January 1, 2010, and expiring January 1, 2015, that would equal the amount of qualified health coverage premiums (not including co-payments and deductibles) paid by pool enrollees in excess of 5.5 percent of their adjusted gross income (AGI). The credit could not exceed specified maximums based on age and family size. To be eligible, an enrollee would have to have a California AGI between 250 percent and 400 percent of the FPL, and not have access to employer coverage through their own employer or their spouse's employer, or be enrolled in or eligible for any coverage or services that the employer pays for and counts as health expenditures for purposes of the pay or play requirement. However, a taxpayer could still gain a credit for premiums paid to cover dependents if the employer plan excludes dependents. The credit would be gradually phased out as the taxpayer's AGI increases from 300 to 400 percent of the federal poverty level (FPL). The amount of credit in excess of a taxpayer's personal income tax liability would be refundable if the Legislature appropriates funds for it.

For purposes of the tax credit, "qualified health care plan premium costs" would be defined as amounts equal to 75 percent of the lesser of the total premiums paid by the enrollee or the premium for a plan from coverage choice category 3. The bill would

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further direct that a coverage choice category 3 plan be one that covers prescription drugs, physician visits, and preventive services, including services to manage chronic conditions, outside of any deductible.

The bill would state the intent of the Legislature to authorize this credit to be advanceable, meaning it is available to be used prior to the taxpayer filing their income tax return. If advances are authorized, MRMIB would apply such advances to pay health coverage premiums on behalf of an individual, spouse, and dependents.

The bill authorizes MRMIB to provide a report to FTB that would include taxpayer and health care premium information to help FTB administer the credit. The bill would also authorize FTB to provide tax return information to MRMIB to administer advancing of the credit, if authorized by the Legislature.

According to information provided by the author, the credit is estimated to cost the state approximately $400 million annually.

In addition, the bill would state the intent of the Legislature to authorize a health care coverage credit for taxpayers who are 50 to 64 years of age who do not qualify for the credit described above. This credit would be allowed only to the extent money is available and subject to an appropriation. The fiscal analysis assumes $50 million annually would be budgeted for this credit.

***Other provisions*.** MRMIB would be authorized to adjust premiums, subject to specified public notice requirements. The bill would authorize MRMIB to make unsubsidized dental and vision coverage available through the pool, as specified, for optional enrollment by all pool enrollees. Additionally, MRMIB would be authorized to allow Cal-CHIPP enrollees who become ineligible for Cal-CHIPP to continue coverage through Cal-CHIPP for, at most, 18 months from the date of ineligibility, if the enrollee pays the entire cost of the coverage.

To provide prescription drug coverage for Cal-CHIPP enrollees, the bill would authorize MRMIB to contract directly with health care service plans or health insurers for prescription drug coverage as a component of a health care service plan contract or a health insurance policy, and/or procure products directly through the state's existing prescription drug bulk purchasing program. Specified public entities, and boards or administrators providing health coverage pursuant to specified labor agreements would be able to participate in prescription drug purchasing arrangements made by MRMIB through the state's prescription drug bulk purchasing program.

The bill would provide a process by which individuals could appeal decisions made by MRMIB regarding Cal-CHIPP eligibility, enrollment, and coverage effective dates. MRMIB would be required to consult with DHCS to seek federal financial support for subsidized coverage, and to apply federal citizenship, immigration and identity documentation standards, to the extent required, to obtain federal financial support.

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The bill would require employers to establish cafeteria plans to allow employees to pay health care coverage premiums on a pre-tax basis, or be subject to specified penalties, and would require MRMIB to establish procedures by which employee premium dollars withheld under a cafeteria plan would be credited against the employee's premium obligations. The bill would authorize employers to pay all, or a portion of, premiums for Cal-CHIPP coverage for their employees, and would also define as an unfair labor practice by employers, the referral of employees and their dependents to the pool in order to separate them from employer-sponsored group coverage, or any modification of employee cost-sharing or coverage levels with the intent to shift them to the pool. The bill would also state the intent of the Legislature that health care expenditures made by employers, as part of the pay or play provisions, not discriminate on the basis of wage level or have the effect of making lower income employees eligible for coverage through the purchasing pool.

Comments and issues

1. ***Affordability protections limited to premium costs.*** Affordability protections for persons with incomes between 150 percent of the FPL and 250 percent of the FPL who qualify for the benchmark plans are limited to premium costs only. While additional cost sharing requirements for this population are assumed to be modest, with these additional costs, these persons would be required to spend more than five percent of their incomes for health coverage. Some of these persons would be subject to the mandate to have minimum coverage; for them, benchmark plans available through the pool would be their best means of satisfying the mandate.

2. Benefits and cost sharing levels for plans in pool depend on revenues. While the bill provides general direction to MRMIB on how to design the benefit packages and cost sharing levels for pool enrollees, the specific design of the plans will depend greatly on the availability of revenues. The fiscal analysis assumes that the average cost of a Cal-CHIPP plan, which is supposed to cover Knox-Keene Act required benefits plus prescription drugs and have cost sharing that promotes prevention and health maintenance, would be $250 per person per month. A preliminary actuarial analysis that examined benefit packages and cost sharing levels that could be provided for that cost, suggests that meeting that cost target would likely require some restrictions on benefits, for example providing brand name drugs only where a generic is not available or is therapeutically required, or reductions in payments to providers below commercial rates, or both. Similarly, the fiscal analysis assumes the maximum tax credits will allow enrollees to purchase a benchmark PPO plan, similar to those in the individual market, without spending more than 5.5 percent of their income, after adjustment for tax savings from using a Section 125 plan. Such a benchmark plan would likely entail individual deductibles on the order of $2,500 per individual or $5,000 per family, with preventive services available outside of the deductible, out of pocket maximums of up to $7,500 per individual or $15,000 per family, coinsurance requirements for use of most services and a separate deductible for brand name drugs. In determining the maximum tax credit levels, the analysis assumed MRMIB would obtain prices for this type of plan, based on age level, equal to those currently offered in the individual market for a popular Blue Cross PPO plan, for the Sacramento region. For most of the enrollees MRMIB would be

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procuring coverage for, these rates would be high, since Northern California is a higher cost region in general than Southern California; at the same time, the assumed rates reflect the exclusion of the persons with pre-existing conditions, which MRMIB would not apply in accepting enrollees, which, all other things being equal, make the assumed rates lower than the rates MRMIB would be able to get. If these estimates are too low, it would mean that pool enrollees who receive the tax credit would be required to spend more than 5.5 percent of their income for premiums, and additional amounts for deductibles and cost sharing, or else choose plans with even higher deductibles and out-of-pocket limits in order to hold their premiums to that percentage of their income.

3. Potential exclusion of part-time and low wage workers from pool and tax credit eligibility. As drafted, significant numbers of part-time and lower wage employees who receive limited health care benefits from employers, either directly or through a spouse, could be excluded from eligibility for the purchasing pool and the tax credit, but would still be subject to the mandate. Some persons, as well as their dependents, could be eligible for coverage under other parts of the bill, for example the Medi-Cal eligibility expansions, but many would need to purchase individual coverage in order to satisfy the mandate. An employer could choose to drop the coverage that applies to these employees, making them eligible for the purchasing pool and credit; however, sections of the bill make it clear that doing so constitutes a Labor Code violation.

4. Premium subsidies for higher income employees limited. Premium subsidies for employees with incomes above 400 percent of the FPL are more limited than those under AB 8 (Nunez), as passed by the Legislature and vetoed by the Governor. AB 8 would have made any employee of an employer who elects to pay an assessment rather than make health care expenditures directly eligible for a subsidy of up to half of the costs of their coverage. ABX1 1 limits the subsidy for these employees to 20 percent of the cost of minimum coverage, which would require many to spend considerably more than five percent of their incomes on coverage if they were to elect more comprehensive coverage.

5. Cost sharing in pool could increase over time. Absent very effective cost containment, it is likely that the costs of coverage provided through the purchasing pool will increase faster over time than the revenue sources supporting the pool, including employer assessments, federal funds, premium contributions (which are capped for lower income employees), and redirected county funds. If the Legislature and Governor did not address this by augmenting funding for the pool, MRMIB's choice would likely be to increase other cost sharing requirements.

6. Stakeholder input on benchmark plan eligibility. The bill does not establish a process for stakeholder input to assist MRMIB in developing its process for determining eligibility for plans, enrolling and disenrolling persons, and handling grievances. In particular, the bill would allow MRMIB to limit enrollment in the pool, develop an eligibility screening and enrollment process, and determine scope of benefits for several coverage packages. In some instances, MRMIB would be making these decisions about Medi-Cal enrollees who are in the Healthy Families or Cal-CHIPP plan. In contrast, Medi-Cal has well-defined procedures for enrollment, termination, notice, appeal, and hearing rights. The Western Center on Law and Poverty argues that these decisions are

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better made by the Legislature, taking into consideration input from stakeholders and other interested parties.

7. Tax credit versus direct subsidy. Tax credits are generally a cumbersome way of providing subsidies. As drafted, taxpayers would be required to pay the costs of their coverage throughout the year and recover the credit when they file their taxes, although the bill expresses intent to make the credits advanceable. Given that the tax credit is only provided for coverage in the pool, and that the intent is to make them advanceable, it is not clear why the bill relies on this mechanism to provide subsidies, rather than providing them directly, as is done for pool enrollees with incomes below 250 percent of the FPL.

8. Early retiree tax credit. Establishment of the separate tax credit for persons between the ages of 50 and 64, who do not qualify for the tax credit administered by MRMIB is dependent on enactment of separate legislation and appropriation.

9. Making the tax credit advanceable is complicated. According to the author, one of the key aspects of the credit is that it is intended to be "advanceable," which means those eligible could use the credit during the year rather than waiting to file their taxes. However, the author has told the committee that because of the complexity of structuring the advanceable provisions, there is merely intent language in ABX1 1. The complication occurs because advancing a credit would require a screening for eligibility which could only be done on a preliminary basis, it would have to interact smoothly with the Section 125 plans employers establish, and would have to be adjusted to changes in eligibility during the tax year based on income and changes in family size. Regardless, there will be taxpayers who receive the advance and will subsequently find that they were not eligible at the end of the tax year and will have to pay the state back. Conversely, some will find out their eligibility too late to enjoy the advanceable aspect. These administrative challenges could make also make advancing the credit expensive to administer.

D. What people would receive, by income level

The table on the following page summarizes the benefits and cost-sharing requirements that would apply to persons who receive coverage through the purchasing pool and tax credit and indicates which persons would be excluded from the pool.

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Benefits and Cost-Sharing Requirements
For Coverage in Purchasing pool, by Income Level

Income	Benefits Inside Pool	Premiums and Cost-Sharing Inside Pool	Comments	Who's Excluded From Benefits
100-150 percent of the FPL ($10,210 to $15,315 for a single person; $20,650 to $30,975 for a family of four)	Cal-CHIPP Healthy Families Plan that meets Knox-Keene requirements, and prescription drug benefits, which, at minimum, cover generic drugs, and brand name drugs when generic is unavailable or patient requires brand name drug.	Enrollees would pay no premiums or other out-of-pocket costs.	Premium costs to MRMIB would be the highest for this category of enrollees because enrollees would pay no part of the premiums and also would not pay for any deductibles, co-payments, or coinsurance for use of services. Premium costs to MRMIB would not be capped and would depend on MRMIBs ability to negotiate below commercial market rates with plans.	Childless adults who have access to employer coverage and persons who are not citizens or legal residents would be excluded from these benefits. If their employer elects to contribute to the pool, childless adults would be eligible for these benefits. Persons excluded from these benefits would likely be exempt from the mandate to maintain minimum coverage, and would not be eligible to purchase individual insurance on a guaranteed issue basis, but could voluntarily accept employer coverage, if available. Minimum benefits and cost sharing requirements for employer coverage are not specified in bill. Those without access to employer coverage could receive primary care services through clinics under the clinic funding expansion in the bill.
150-250 percent of the FPL ($15,315 to $25,525 for a single person; $30,975 to $51,625 for a family of four)	Cal-CHIPP Healthy Families Plan that meets Knox-Keene requirements, and prescription drug benefits, which, at minimum, cover generic drugs, and brand name drugs when generic is unavailable or patient requires brand name drug.	Premium costs limited to 5 percent of family income. MRMIB would be required to establish enrollee cost-sharing levels that promote prevention and health maintenance, including office visits, lab services, and medications to manage chronic disease.	Premium costs to MRMIB for this category of enrollees would be somewhat lower than those for enrollees with incomes between 100 and 150 percent of the FPL because enrollees in this income range would pay a portion of the premiums, capped at 5 percent of income, and could also be required to pay deductibles, co-payments, and/or coinsurance for use of services. These cost sharing are not specified, but are required to be at levels that "promote prevention and health maintenance." MRMIB would determine the actual cost sharing levels enrollees would be subject to. Premium costs to MRMIB would not be capped and would depend on MRMIBs ability to negotiate below commercial market rates with plans.	Childless adults who have access to employer coverage and persons who are not citizens or legal residents would be excluded from these benefits. If their employer elects to contribute to the pool, childless adults would be eligible for these benefits. Most, but not all, persons excluded from these benefits would likely be exempt from the mandate to maintain minimum coverage, and would not be eligible to purchase individual insurance on a guaranteed issue basis, but could voluntarily accept employer coverage, if available. Minimum benefits and cost sharing requirements for employer coverage are not specified in bill. Those without access to employer coverage could receive primary care services through clinics under the clinic funding expansion in the bill.

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Income	Benefits Inside Pool	Premiums and Cost-Sharing Inside Pool	Comments	Who's Excluded From Benefits
250 percent of the FPL and above ($25,525 and up for a single person; $51,625 and up for a family of four)	MRMIB would be required to make available, at minimum, one plan from coverage choice categories 1, 3, or 5. Plans in coverage choice category 3 would be required to cover prescription drugs, physician visits, and preventive services outside of any deductible.	Enrollees with incomes between 250 and 400 percent of the FPL would be eligible for a tax credit equal to premium costs in excess of 5.5 percent of income, reduced for persons with incomes above 300 percent of the FPL, and capped. Enrollees with incomes in excess of 250 percent of the FPL would be eligible for a contribution from MRMIB in an amount equal to 20 percent of the premium cost of a tier 1 plan (minimum health care coverage) to any plan enrolled in by the employee.	Premium costs to MRMIB for plans would vary depending on the level of benefits. Premiums to MRMIB would not be capped and would depend on MRMIBs ability to negotiate below commercial market rates with plans. The maximum tax credit would be tied to the cost of a coverage choice category 3 plan; if enrollees were to choose this type of plan, their share of the premiums would be limited to 5.5 percent of income. MRMIB would determine the actual level of deductibles, co-payments, coinsurance, and out-of-pocket maximums for the plans that these enrollees would have access to. For purposes of the modeling and fiscal estimates that were prepared by Dr. Jonathan Gruber, a tier 3 plan was assumed to be a plan with a $2,500 deductible per person, or $5,000 per family; 30 percent coinsurance rate for use of services; maximum out-of-pocket limits of $7,500 per individual or $15,000 per family; and a separate $500 deductible for brand name drugs.	Persons in this income range who have access to employer coverage would not be eligible to purchase coverage through the pool and would be excluded from the tax credit and 20 percent discount. If their employer elects to contribute to the pool, they would be eligible for the tax credit and/or 20 percent discount, depending on their income. Persons excluded from these benefits could elect to accept the employer coverage, but would be ineligible for primary care services under the clinic funding expansion in the bill. Most persons in this income range would likely be subject to the mandate to maintain minimum coverage, and would be eligible to purchase individual insurance on a guaranteed issue basis.

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E. Clinic funding provisions – sections of the bill 3 1.1-3 1.5

Existing law establishes the Expanded Access to Primary Care (EAPC) program which reimburses licensed primary care clinics for uncompensated care provided to program beneficiaries, defined as any person with an income at or below 200 percent of the FPL. In order to be eligible for EAPC reimbursement, a clinic must be located in a designated health professional shortage area or medically underserved area, have at least 50 percent of its patients at income levels at or below 200 percent of the FPL, and provide specified health care services to program beneficiaries, including diagnosis and treatment, health education and prevention services, and services to patients with chronic illnesses.

The law prohibits EAPC program beneficiaries from having to make co-payments for services, but does allow clinics to charge beneficiaries on a sliding fee scale. No beneficiary may be denied services because of an inability to pay.

This bill would increase income eligibility requirements for EAPC program beneficiaries from the current 200 percent of the FPL to 250 percent of the FPL. It would also limit eligibility to persons who either do not have private or employer-based health care coverage, or who are not currently enrolled in, or eligible for, public coverage programs**,** including the purchasing pool established by the bill. Program beneficiaries would be required to select a clinic as a primary care medical home, and would be issued a primary care card upon determination of eligibility to be used at the designated medical home. A clinic would be required to serve as a designated primary care medical home for its program beneficiaries in order to remain eligible for EAPC reimbursement.

The bill would require DHCS, on or before July 1, 2010, to develop an electronic system to provide an eligibility application for program beneficiaries, verify annual income of applicants, and issue the primary care clinic card. It would also authorize DHCS to contract with other entities, or use existing provider enrollment and payment mechanisms to implement the bill's provisions.

Comments and issues

1. Proposed budget cuts to program. The Governor proposes a 15 percent ($4.5 million) reduction to the EAPC program for the fiscal year 2008-09. According to the California Primary Care Association, based on these proposed reductions, the EAPC program would be unable to reimburse clinics for approximately 63,000 uncompensated patient visits. The fiscal summary of ABX1 1 assumes the program would be augmented by $140 million in the first full year of implementation. If the proposed budget cut were approved, to provide the same service level as provided by ABX1 1, the Legislature and Governor would have to backfill it using ABX1 1 revenues, or other revenues.

2. Expanded clinic coverage may not satisfy mandate. While the bill expands eligibility for the EAPC program in order to provide greater access to primary and preventive care to persons who don't qualify for the other public program expansions, purchasing pool, and tax credit, enrollment in the program is not likely to satisfy the mandate. The author has indicated that MRMIB would have the authority to exempt EAPC enrollees from the

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mandate, but the bill does not explicitly require that. Even though enrollees would be limited to those with incomes below 250 percent of the FPL, some, particularly those who are younger and/or live in areas where health insurance rates are lowest, could otherwise find themselves subject to the mandate.

F. Ryan White premium and cost sharing provisions

This bill would state legislative intent that the state develop and implement a transition plan, by July 1, 2010, to permit the state to use funding from the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 and other funding to pay for premiums and cost-sharing burdens associated with insurance coverage. According to the administration and the author, the intent of this provision is to permit federal money available under Title II of the Ryan White CARE Act or other funds (i.e., State funds) to be used towards any cost sharing requirements for individuals with HIV/AIDS who transition from the AIDS Drug Assistance Program (ADAP) to Cal-CHIPP or private coverage.

III. Provisions affecting coverage outside of the purchasing pool.

The net result of the changes in ABX1 1 is that most people are likely to continue to receive their health coverage from an employer, and some will have no other recourse but to purchase it in the individual market in order to satisfy the mandate, while roughly 1.5 million of the 5.1 million residents who are currently uninsured would likely remain uninsured. Together these three groups will receive coverage and/or services outside of the purchasing pool and outside of public programs. The following is an analysis of how the bill impacts the extent and cost of coverage or services for these groups.

A. Employer provided coverage

As drafted, employer coverage that is provided through licensed HMOs and health insurance plans would still be subject to state mandated benefit laws. In addition, depending on how MRMIB defined the mandate to maintain minimum coverage, and how they applied the mandate to group plans or enrollees in group plans, some current employer plans may have to be expanded to include additional benefits, for example outpatient services, maternity coverage or prescription drug coverage. Other than this, employer plans would not be subject to any particular standards in terms of their scope of benefits. There are virtually no limits where an employer offers coverage instead of paying in to the pool, on how much of the total cost an employer can require an employee to pay. The bill effectively simply allows MRMIB to establish limits as part of the definition of minimum creditable coverage, for example, a requirement that preventive services be provided outside of any deductible, and maximum limits on total out-of-pocket costs. No specific subsidies would be provided for employees who receive employer sponsored coverage other than an across the board requirement that all employers establish Section 125 accounts to allow their employees to pay for health coverage costs with pre-tax dollars. However, because of the employer health contribution thresholds, some employees may experience an increase in the percentage of the coverage that is borne by the employer. According to modeling estimates from MIT

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economist Jonathan Gruber, close to 19 million of the state's 32 million nonelderly residents would be covered in group insurance arrangements after the enactment of ABX1 1, a slight increase from the number currently in such coverage arrangements. Some of the net changes would be accounted for by people moving from individual coverage, which is generally more expensive for individuals, provides fewer benefits, and requires higher cost sharing than group coverage.

B. Individual insurance market

Coverage in the individual market would be subject to new minimum benefit standards resulting from the definition of minimum creditable coverage adopted by MRMIB. These standards are likely to be more expansive than those that currently apply to the individual insurance market and may include cost sharing limits that are more generous than some plans currently provide. In addition, with the addition of guaranteed issue and rating restrictions, individuals purchasing in the individual market would be able to obtain coverage regardless of medical condition and would eventually pay rates based solely on their age, family size, and place of residence. These reforms could have the effect of making health insurance more expensive than it currently is for many policy-holders, if plans and insurers price individual insurance with the assumption that enforcement of the minimum coverage mandate will be weak and that people will wait until they have medical needs before seeing it. Persons purchasing in the individual market who are employed would receive the benefit of using a Section 125 plan to pay their premiums, if they don't currently have one. Other than this, no subsidies or affordability protections would be available to persons who enroll in these plans. According to Dr. Gruber's estimates, the non-group market would decline by about 300,000 persons after the enactment of ABX1 1 to about 1.7 million individuals.

C. Uninsured

Persons who remain uninsured after enactment of ABX1 1 would include persons who are exempt from the mandate, do not qualify for the coverage expansions, purchasing pool, or tax credits, or choose not to comply with the mandate. According to Dr. Gruber's estimates, approximately 1.5 million persons would fall in this category. These persons would continue to rely on county and private safety net providers for care. The bill's expansion of the EAPC program would enable uninsured residents to receive regularly scheduled medical care, with referral to public and private hospitals for hospital care.

IV. Health insurance market and regulatory reforms - sections of bill: 19, 21-28.5, 34.3-36, 38-42

A. Guaranteed issue requirements

Existing law requires full-service health plans and health insurance policies in the individual market to have written policies, procedures, or underwriting guidelines establishing the criteria and process under which the plan makes decisions to provide or to deny coverage to individuals applying for coverage, and sets the rate for that coverage.

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Existing law requires all individual benefit plans to be renewable by all eligible individuals or dependents except for nonpayment of premiums, as well as fraud or intentional misrepresentation, among other reasons.

Existing law does not generally require health plans and insurers to offer coverage to individuals without regard to medical factors. One exception is that federal and state laws require health plans and health insurers in the individual market to issue coverage to "federally eligible defined individuals," defined as persons who have had 18 months of prior group coverage and are not eligible for other group or public coverage. Existing federal and state laws also allow individuals to retain group health coverage for a period of time when experiencing a qualifying event, as defined. Existing law also requires health care service plans and health insurers to allow employees or members whose group coverage was terminated by the employer to convert to non-group coverage without consideration of health status.

This bill would, beginning July 1, 2010, require health plans and insurers to offer, market, and sell, on a guaranteed issue basis, all of their contracts or policies sold to individuals, and would prohibit them from rejecting applicants or canceling or refusing to renew policies, with exceptions. The exceptions would include persons who are exempt from the mandate to enroll in and maintain minimum creditable coverage. These requirements would become effective once MRMIB has established methods to inform individuals of health care coverage options and to ensure that they obtain the minimum required coverage. Health plans and insurers would also be prohibited from imposing preexisting condition exclusions, waivered conditions, or waiting periods for coverage. The exception to this would be that health plans and insurers would be allowed to impose a preexisting condition exclusion period for a person who fails to maintain minimum creditable coverage for a period of more than 62 days, equal to the length of time the person failed to comply with the mandate. The bill would also, effective July 1, 2010, prohibit plans and insurers from rescinding individual health plan contracts and policies.

On or before April 1, 2009, DMHC and DOI would be required to develop, by regulation, a system to categorize health plan contracts and insurance policies into five coverage categories, reflecting a reasonable continuum of benefits and prices. Health plans and insurers that offer individual coverage would be required to offer at least one plan in each coverage choice category. The coverage category with the lowest level of benefits would be required to provide the minimum coverage as established by MRMIB. Individuals would only be able to change from one coverage category to another on the anniversary of the date they signed up for the coverage, or upon a qualifying event, as defined, and would only be permitted to move up one coverage category at a time. Health plans and insurers would be required to submit filings by October 1, 2009 for plan contracts and policies to be offered or sold after July 1, 2010.

B. Coverage tiers and rating restrictions

Effective July 1, 2010, health plans and insurers would be required to charge premiums for individual health plan contracts and policies that reflect standard risk rates based on established age, family size, and geographic region rating categories. However, for the

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first four years following implementation, health plans and insurers would be allowed to apply a risk adjustment factor based on the health status of the individual, using a standard form and evaluation process that would be developed by the DMHC Director and Commissioner. For the first two years following implementation, the initial risk adjustment would be up to 20 percent above or below the standard risk rate; for the second two years, the risk adjustment would be limited to plus or minus five percent of the standard risk rate. During both periods, upon the renewal of any contract or policy, the change in the risk adjustment factor for an individual would be limited to 10 percent. After the first four years following implementation, rates would have to be based on the standard risk rate with no risk adjustment factor. The DMHC Director and Commissioner would also be required to jointly establish a maximum limit on the difference between standard risk rates for individuals in the 60 to 64 age category and those in the 30 to 35 age category. Prior to making any changes in the standard risk rates, plans would be required to certify that they are in compliance with these requirements.

Notwithstanding these requirements, the bill would allow health plans and insurers to renew, indefinitely, contracts and policies that provide less than minimum creditable coverage for persons who are enrolled in them on March 1, 2009, and would deem individuals enrolled in them to be in compliance with the mandate to maintain minimum creditable coverage. These plans and policies would not be available to new enrollees after that date.

The proposal would require health plans and insurers to make standard disclosures in their solicitation and sales materials concerning their plans and rates. Health plans and insurers that cease to write new individual health coverage would be prohibited from offering individual coverage in the state for a period of five years. The proposal would state that it is not to be construed as providing the DMHC Director or Insurance Commissioner with rate regulation authority.

C. Reinsurance provisions

The DMHC Director, in consultation with the Commissioner and others, would be required, no later than July 1, 2010 to develop mechanisms to ensure the equitable spreading of risks in the individual market, including, if necessary, through a risk adjustment mechanism and an interim and a permanent reinsurance mechanism. The latter would be developed if the relative risk profile of persons enrolled in individual coverage is higher than that of persons enrolled in the purchasing pool. Costs of reinsurance to compensate for a risk profile differential of up to 10 percent would be borne by plans and insurers themselves; costs of reinsurance for a differential in excess of that would be paid for from revenues in the Health Care Trust Fund.

D. Medical loss ratios

Existing law prohibits health care service plans (health plans) from expending excessive amounts of the payments received for providing services on administrative costs, as defined. Existing regulations further provide that the definition of administrative costs shall take into consideration such factors as the plan's stage of development. If

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administrative costs exceed 15 percent for an established plan, or 25 percent for a plan in a development phase, the plan may be required to justify its administrative costs and/or show that it is taking effective action to reduce administrative costs.

Existing law requires the Insurance Commissioner to withdraw approval of an individual or mass-marketed policy of disability insurance if the Commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged. Existing regulations define a standard of "reasonableness" for the ratio of medical benefits to the premium charged for individual health insurance, and sets this ratio at 70 percent, as of July 1, 2007.

This bill would, on and after July 1, 2010, require full-service health plans and health insurers to expend no less than 85 percent of the after tax revenues they receive from dues, fees, premiums, or other periodic payments, on health care benefits. The bill would allow plans and insurers to average their administrative costs across all of the plans and insurance policies they offer, with the exception of Medicare supplement plans and policies and certain other limited benefit policies, and would allow DMHC and the Department of Insurance (DOI) to exclude any new contracts or policies from this limit for the first two years they are offered in California. "Health care benefits" would be broadly defined to include the costs of programs or activities which improve the provision of health care services and improve health care outcomes, as well as disease management services, medical advice, and pay-for-performance payments.

E. Other health insurance regulation provisions

- Existing law prohibits plans and insurers from basing compensation of claims reviewers on the number or amount by which claims are reduced or denied. This bill, effective December 1, 2008, would additionally prohibit plans and insurers from basing compensation of persons who review eligibility determinations on these factors.

- Existing law establishes within DMHC the Office of Patient Advocate, to develop educational and informational guides for consumers, to publish an annual health plan report card, and to provide assistance to enrollees regarding their rights and responsibilities under their health plans. Under the bill, the Office of the Patient Advocate would additionally be required to develop and maintain a website providing standard information on all individual health plan contracts and policies.

- The bill would allow health plans and health insurers to provide certain notices by electronic transmission if they obtain written authorization from the applicant, enrollee, or subscriber and meet other requirements.

- Existing law subjects Medi-Cal managed care plans to regulation by both DMHC and the DHCS. This bill would provide that Medi-Cal managed care plans shall be subject solely to health plan filing, reporting, monitoring, and survey requirements as established by DHCS, and would require DMHC and DHCS to develop a joint process for carrying out medical quality surveys.

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- Existing law requires health plans that provide prescription drug benefits and maintain one or more drug formularies to provide, upon request, a copy of the most current list of prescription drugs on the formulary. This bill would require a health plan, commencing January 1, 2010, to make the most current formularies available electronically.

Comments and issues

1. Impact of reforms on rates. Health plans and insurers express concerns that requiring plans and insurers to provide coverage to all who seek it will likely increase costs in the individual market by forcing insurers to issue policies to individuals who have no incentive to seek coverage until they become sick or have health problems. Plans are concerned that it will be difficult to effectively enforce the bill's mandate to enroll in and maintain minimum creditable coverage and that MRMIB will have authority, and be under pressure, to create additional exemptions from the mandate. Together, these outcomes could create an environment where people tend to wait until they have medical needs before seeking coverage in the individual market. Plans are further concerned that the modified community rating provisions in the bill will result in higher rates for younger and healthier persons, both those who have existing coverage and those who seek it after the provisions of the bill take effect. The author and administration maintain that these concerns are mitigated by several provisions of the bill including the process to automatically enroll persons who lack minimum coverage into such coverage, the expectation that MRMIB will be judicious in its consideration of additional exemptions, provisions allowing healthier persons to remain in sub-minimum plans if they enroll in such plans by March, 2009, and the risk adjustment and reinsurance mechanisms provided by the bill.

2. Potential for healthier risks to go into sub-minimum coverage. Under the bill, health plans and insurers could market sub-minimum coverage in the individual market until March, 2009, including offering new contracts and policies and renewing existing ones. At that point, plans and insurers would not be able to market new contracts and policies that don't meet standards for minimum creditable coverage issued by MRMIB. This could give plans and insurers an incentive to enroll additional healthy lives before the guaranteed issue and rating reforms take effect in 2010, which in turn would make the pool of persons whom carriers have to guarantee issue to, and reduce use of medical underwriting for, older and sicker than it would otherwise be. These incentives would be mitigated, but not eliminated, by the fact that plans and insurers would not know until November, 2008 whether the reforms were going to be taking effect, and by the fact that plans and new insureds wouldn't know until March, 2009 what the definition of minimum creditable coverage was going to be. Although people could accept coverage that ended up not meeting the minimum standard, and could remain in it indefinitely, some would be deterred from accepting it because their ability to move up to more comprehensive coverage in the future would be limited under the bill.

3. ***Not clear how plans and insurers would determine who is exempt from the mandate.***

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The bill would allow plans and insurers to decline to issue coverage to persons who are exempt from the mandate to have insurance, which is a different and more restrictive policy than is in place in Massachusetts. Plans and insurers have argued that people who are exempt from the mandate are more likely to seek insurance when they are sick or have medical needs, and that they need the flexibility to underwrite and price accordingly. However, it is not clear under the bill how plans would know who falls into this category, unless they have access to accurate income information or unless MRMIB issues some form of certification to that effect, which they would likely only do for the limited number of hardship or affordability exemptions they have granted individually.

4. ***Ability to contain health coverage rate increases unclear.*** Despite the various cost containment provisions in ABX1 1, including new proposed medical loss ratio requirements, and the new bargaining power that MRMIB would have in administering the proposed purchasing pool, the bill's lack of provisions for review or approval of health insurance rates raises questions whether the proposal would be successful in stemming the rate of increase in health insurance rates.

5. ***Bill lacks requirements to disclose medical loss ratios for individual policies and contracts.*** The bill would allow plans and insurers to average administrative costs across all policies and contracts, which would allow them to keep loss ratios low on commercial plans and offset them with higher loss ratios on Medi-Cal managed care plans, instead of establishing separate loss ratios on each type of policy or contract. The bill also does not require plans and insurers to routinely disclose their loss ratios on their different policies and contracts.

V. Financing provisions – sections of bill: 78-83; sections of initiative: 4-19

The bill expresses intent that the provisions of the bill be financed through federal Medicaid and SCHIP matching funds, revenues from counties to support the cost of enrolling persons who would otherwise be entitled to county-funded care, fees paid by acute care hospitals at a rate of four percent of patient revenues, fees paid by employers, premium contributions from employers who offer coverage to employees who are eligible for public programs, premium payments from individuals enrolled in publicly subsidized coverage and in the individual market, funds from a new tobacco tax, and through savings in reduced demand for existing health care programs.

Many of the actual financing provisions for ABX1 1 are contained in a proposed initiative entitled, "The Secure and Affordable Health Care Act of 2008," which was submitted to the Attorney General for title and summary on December 28, 2008. The proposed initiative contains four major financing elements, a proposed $1.75 per pack tobacco tax; a requirement that employers pay a health care contribution equal to a specified percentage of wages, with a credit equal to the amount they spend on health expenditures, as defined; a requirement that counties make payments to the state for health care costs incurred by the state in providing health care coverage to low-income adults, as specified; and an assessment on the net patient revenues of acute care hospitals, as specified. The initiative would establish a California Health Trust Fund for receipt of

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revenues from these sources, and would deem them to be revenues that are not subject to Proposition 98, the school funding initiative, and the Gann limit.

Other sources of financing that are not in the proposed initiative and do not require voter approval include funds received from employers for employees who are eligible for employer provided coverage and who are also eligible for public health coverage programs; these funds would either be collected from the employer or the state and would "wrap around" employees by supplementing the employer's plan. Non-initiative funding would also include premium contributions from employees seeking coverage through the purchasing pool, federal Medicaid and Title XXI SCHIP matching funds for the eligibility expansions and Medi-Cal rate increases proposed in the bill, and projected savings from reduced utilization of programs offering limited health care services that overlap with the new programs created by the bill.

The initiative additionally contains language stating that it is being enacted with the expectation that the Legislature passes and the Governor signs a bill that is "essentially the same" as ABX1 1 as amended December 17, 2007. The initiative also provides that its provisions may be amended by the Legislature with whatever vote requirement would otherwise apply, but specifically requires that provisions pertaining to the Director of Finance's responsibilities and the hospital assessments must be amended with a 2/3 vote.

The initiative also contains a severability clause, providing that if any provision is found to be invalid or unconstitutional, the remaining provisions shall not be affected and provides that it shall not limit the ability of the Legislature to amend ABX1 1 after the initiative is passed by voters.

A. Employer health care contributions – section of the initiative: 8

The proposed initiative would, on and after January 1, 2010, require employers to pay health care contributions, at a rate ranging from 1 to 6.5 percent of total Social Security wages paid to employees. The contributions would equal 1 percent of prior year wages for employers with an annual payroll of $250,000 or less, 4 percent for employers with an annual payroll between $250,000 and $1 million, 6 percent for employers with an annual payroll between $1 million and $15 million, and 6.5 percent for employers with an annual payroll in excess of $15 million. Every employer would be eligible for a credit to offset the required health care contribution in the same amount the employer spends on health expenditures for employees and their dependents.

The proposed initiative would define employer health care expenditures as any amount paid by an employer to, or on behalf of, its employees and their dependents, if applicable, to provide health care or health-related services or to reimburse the costs of those services, including, but not limited to, contributions to Health Savings Accounts (HSAs), specified unreimbursed employee health care costs, healthy lifestyle programs, on-site health fairs and clinics, contributions for health expenditures made under collective bargaining agreements, disease management programs, pharmacy benefit manager programs, purchasing health care coverage, and care provided by health care providers employed by, or under contract to, the employer.

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The proposed initiative would require employers to remit any health care contributions to the Employment Development Department (EDD) by the 15th day of each month. Health expenditures made by employers as required by a collective bargaining agreement would satisfy the employer health care contribution requirement. Employers would be required to pay separate contributions for each bargaining unit within an employee organization, as specified. EDD would be prohibited from accepting contributions made by employers on behalf of bargaining unit employees without the consent of the representing labor organization.

Under the initiative, employer contributions for IHSS providers would be the responsibility of the state and county. IHSS consumers would not be defined as an employer for the purposes of employer contribution requirements. Additionally, the proposed initiative would provide that self-employed individuals who conduct business through a loan out corporation, under which they receive income, would not be held liable for health care contributions in excess of the percentage of payroll required based on the total wages of the corporation**.**

The proposed initiative would require EDD to establish methods to collect employer contributions, and would authorize EDD to use its existing authority and procedures to collect employer health care contributions owed to the state. The initiative would impose specified confidentiality requirements on information obtained in the administration of the employer contribution requirements, but would authorize EDD to release specified information to MRMIB and DHCS as needed for the administration of the requirements. EDD would be required, by January 1, 2010, to adopt regulations to implement the employer health care contribution requirements.

The provisions of the initiative related to employer assessments could be amended by the Legislature in accordance with vote requirements that apply under current law. For example, any provision that would raise a tax would require a 2/3 vote of each house; other provisions would require a simple majority vote of each house.

Comments and issues

1. No part-time test for employer contributions. The proposed initiative requires employers to make health care contributions that meet a percentage of their aggregate payroll, rather than contributions based on separate payrolls for full-time and part-time workers. Many employers could meet their payroll spending threshold while making very limited or no qualified health care expenditures for part-time or low-wage workers. In that case, they would not be required to provide any funding for the purchasing pool, even though many of these employees might be eligible for coverage through the pool.

2. Potential for "crowd-out" of existing employer spending. Existing data suggests that what most employers currently spend on health care benefits is considerably in excess of the required contribution levels established by the initiative. The median among all employers is currently approximately 8 percent; among employers of low-wage workers, it's closer to 20 percent. Employers would find themselves spending more than the required contribution levels for several reasons, including that they employ mostly lower

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wage employees, for whom the cost of health coverage, as a percent of payroll, is higher, that they have older and sicker employees on average and pay rates higher than average, or that they have chosen to provide relatively generous coverage to attract and maintain employees. Under the bill, many of these employers would be allowed to pay contributions that are significantly less than the actual cost of covering their employees, which could create issues for the financial viability of the pool.

3. Not clear EDD could penalize employers who fail to make health care contributions. The proposed initiative does not clearly authorize EDD to levy penalties on employers who fail to pay or underpay health care contributions they are obligated to pay. The initiative does allow EDD to use its existing authority to "collect" contributions owed to the state, but it's not clear from the language that that would extend to levying penalties for noncompliance.

4. No specific penalties for misclassification of employees. As drafted, it is also not clear if EDD could assess penalties against employers who willfully classify employees as independent contractors for the purposes of reducing the health care contributions for which they would otherwise be liable.

5. No provision for start-up costs. The bill and initiative make no provision for start-up costs that EDD is likely to incur in implementing the payroll reporting and employer fee collection processes that would be required by the bill.

6. Self-employed excluded from employer contribution provisions and from coverage through pool. As drafted, self-employed individuals would not be subject to the employer contribution requirements but would also not be eligible for coverage through the purchasing pool unless their income is low enough to qualify for one of the coverage expansions.

7. Initiative may be subject to ERISA challenge. A number of groups have indicated that they believe the initiative is preempted by the Employee Retirement Income Security Act (ERISA), which regulates employer sponsored employee benefit plans, and have indicated that they intend to file legal challenges to the initiative.

B. Other employer revenues - section of the bill: 20.5

Under existing law, the Medi-Cal program is authorized to carry out premium assistance. Premium assistance occurs where another source of funds, typically employer funds, are used to help defray the cost of coverage for those enrolled in public programs. ABX1 1 would establish that the intent of the Legislature is to establish mechanisms by which the state may defray the costs of an enrollee's public program participation. The bill would require DHCS to consult with DMHC and DOI to determine exactly how to implement enhanced premium assistance programs and report their findings to the Joint Legislative Budget Committee by July 1, 2009.

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Comments and issues

1. Utilizing dollars from employers likely to be difficult. In practice, states have had difficulty capturing employer contributions towards health coverage to employees who qualify for public health coverage programs. Designing public coverage to "wrap around" existing employer coverage is administratively cumbersome because employers' plans vary greatly. Redirecting employer contributions to the state, to help pay for coverage through public programs for the employees, is difficult to do without imposing a mandate on employers. In practice, it may be difficult to achieve the nearly $1 billion in funding the fiscal analysis assumes would come from these payments.

C. Redirection of county funds –section of the initiative: 9, 10, 11

Under the initiative, counties would share in the costs of program expansions under the premise that they would receive savings, as counties are currently responsible for providing health care to indigent persons who have no other means of paying for necessary medical care as required by Section 17000 of the Welfare and Institutions Code. Counties use a variety of funding sources for this mandate, including realignment funds (consisting of a portion of state sales taxes and vehicle license fees (VLF),) Proposition 99 tobacco tax funds, county funds, and fees paid by patients.

Counties use a variety of mechanisms to provide this care. Some operate public hospitals and clinics, while others contract for these services. Thirty-four smaller counties participate in the County Medical Services Program (CMSP), established in 1983, which contracts for services and arranges for care for indigent patients in those counties. Data on county expenditures for indigent care is inadequate. However, recent estimates suggest that counties may spend only $250-$750 annually per person on care for the medically indigent, well below the estimated cost of providing health coverage, which has been estimated to be $3,000 to $4,000 annually per enrollee.

The initiative would require counties to pay 40 percent of the cost of the coverage expansions for three groups: 1) Medi-Cal eligibility for medically indigent adults with incomes below 100 percent of the FPL, 2) Medi-Cal expansion for parents and caretaker relatives and 19- and 20-years-old with an income of 150 percent of the FPL or less, and 3) those receiving subsidized coverage through the purchasing pool whose incomes are below 150 percent of the FPL. The initiative would cap these payments at $1 billion annually. ABX1 1 would require that expanding coverage to low income adults would be contingent upon the counties paying a share of the costs.

The initiative would provide that the specific amount each county must pay will be determined by subsequent statute. The initiative directs the Department of Finance, in consultation with counties, to recommend to the Legislature a methodology or formula which would have to be enacted by statute. The initiative also provides that a county can ask the state for temporary modification of the formula if it is suffering from fiscal distress from unexpected high costs or expected savings do not materialize.

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All of the provisions related to the county share of cost may be amended by the Legislature with a majority vote.

Comments and issues

1. Some counties may not benefit as much as assumed. While counties would enjoy some savings from the program expansions, counties and public hospitals express concerns that the proposal would redirect realignment funds from counties without taking into account whether their cost of serving indigent patients has actually decreased. Another factor affecting county costs is that they will still have Section 17000 obligations for this population for some mental health, substance abuse and dental care programs. Small- and medium-sized counties that do not have a public hospital may face more risks as they will not benefit as much from the hospital rate increase.

2. The proposed budget contains provisions that could lead to higher county costs for indigent care. The Governor's budget contains proposals to cap dental care for adults in Medi-Cal. In addition, the Governor's proposed budget contains provisions that increase the administrative requirements associated with Medi-Cal. These actions could also increase the cost of the counties' Section 17000 obligations.

D. Tobacco tax - section of the initiative: 7

Existing state law imposes a tax on distributors of cigarettes and tobacco products at specified rates. The existing taxes imposed by law are equal to 87 cents per pack of 20 cigarettes and are allocated in the following manner:

- 10 cents to the General Fund;
- 25 cents to the Cigarette and Tobacco Products Surtax Fund (created by Proposition 99 in 1988);
- 2 cents to the Breast Cancer Fund (created by AB 478 in 1993); and
- 50 cents to the California Children and Families Trust Fund (created by Proposition 10 in 1998).

For other tobacco products (including cigars, smoking tobacco, chewing tobacco, snuff, and products containing at least 50 percent tobacco), Proposition 99 imposes a tax on the wholesale cost of the tobacco products distributed at a rate which is equivalent to the combined rate of tax imposed on cigarettes. In addition, Proposition 10 imposes an additional tax on tobacco products which is equivalent to a 50-cent per pack tax on cigarettes.

The initiative that accompanies ABX1 1 would impose an additional $1.75 per pack tax on cigarettes, beginning in May, 2009. Existing law enacted in Proposition 99 would require that the tax on tobacco products be raised by an equivalent amount as determined by the Board of Equalization (BOE). The initiative would require the BOE to administer the tobacco tax provisions, including collecting the tax, which is consistent with existing law.

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Comments and issues

1. Tobacco tax revenues may not keep up with forecasted increases in program costs. The proportion of Californians who smoke has consistently declined. Tobacco tax revenues have not grown with the overall economy and income growth. Tobacco revenues have been declining except when there have been rate increases or increased efforts against tax evasion. Although an increase in tobacco tax revenues is expected with a rate hike, the overall proportion of smokers will decline even more rapidly in the face of higher prices. The failure of tobacco taxes to grow could provide a revenue shortfall for the ABX1 1 proposal, a problem exacerbated by the rapid growth of medical costs beyond the rate of overall inflation.

2. The tobacco tax in the initiative will affect the revenues from the other state tobacco taxes. The higher price of cigarettes and tobacco products will mean higher revenues, but will also have the effect of reducing consumption, which in turn will reduce revenues for the current tobacco taxes and the purposes that they serve. As a result, the initiative would backfill, that is hold harmless, the other programs and funds to the extent they are affected by this tax. There are exceptions. The California Children and Families Trust Fund will not be backfilled for the amount of funds that were spent on health insurance for children in the 2007-2008 fiscal year. The Hospital, Physician Services, and Resources accounts in the Cigarette and Tobacco Products Surtax Fund would not be backfilled.

3. Higher taxes could mean greater tax evasion. Purchase of cigarettes through avenues that escape taxation has been a continuing problem for both the state and federal government. The state has instituted measures to reduce this evasion, with some success. The higher the tax, the greater the incentive to market and/or purchase untaxed cigarettes. A number of law enforcement groups have expressed concern that the tax increase in the bill could lead to an increase in illegal trafficking of cigarettes.

E. Federal funds - sections of bill- 48,53, 62-65,67,71,72,77; sections of the initiative: 12

Many components of ABX1 1 rely on federal funding, at least in part. The coverage expansions, except for undocumented children, rely on federal Medicaid funds. The Medi-Cal hospital rate increase relies on federal matching of the assessment to provide the increased payments for public and private hospitals.

ABX1 1 would also require changes in existing use of federal funds that would require federal approval. The proposal would reduce from $540 million to $100 million the amount of funds available annually to the public hospitals from the Safety Net Care Pool (SNCP) and would also redirect $180 million in funds that certain counties are receiving for implementation of the current hospital waiver coverage initiative program. Disproportionate share hospital (DSH) funds, which are payments to hospitals that serve a large number of Medicaid and uninsured, would be redirected to coverage. The coverage expansions, insurance mandate and higher Medi-Cal rates are expected to reduce uncompensated costs that hospitals incur. With the decline in uncompensated

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costs, the state would not be able to claim DSH funds. To maintain the use of these funds, the state would request federal approval to use DSH funds for other purposes, such as coverage expansions.

ABX1 1 would alter Medi-Cal and other payments to 20 designated public hospitals under the state's hospital demonstration waiver, which was approved in 2005. Under the waiver, these hospitals receive Medi-Cal payments for services to Medi-Cal patients, up to established limits, but must use their own documented expenditures (referred to as "certified public expenditures") as the state match. ABX1 1 would set up a different system which would require federal approval.

Comments and issues

1. Host of federal approvals required. Some elements of ABX1 1 are very likely to receive federal approvals; for others gaining the necessary approvals may be more difficult. Many of the major components have been approved in other states, although not as a complete package. By the time, federal approvals are sought there will be a new administration and, perhaps, different policies. Given these uncertainties, there is some risk to the proposal until the federal government has approved these options.

2. State is unlikely to obtain adequate SCHIP funding for children's expansion. Congress and the President have come to an agreement on SCHIP funding, which was reauthorized in late 2007. The proposed funding levels will not support the size of the expansion envisioned in ABX1 1. However, the state can use Medicaid funds, although the matching rate, 50 percent, is less advantageous than the rate for SCHIP. The funding levels for SCHIP could change as Congress must reauthorize the program in March of 2009.

F. Hospital assessments – section of initiative: 12

The initiative provides for a new hospital fee of 4 percent of aggregate net patient revenue of hospitals. Private and small public hospitals would pay the state approximately $1.7 billion in fees in the first year of implementation, an amount which would be almost doubled by obtaining federal matching funds. The total amount of $3.3 billion would then be paid to hospitals based on a formula contained in the bill. The hospitals would receive a rate increase of approximately $1.5 billion for both inpatient and outpatient services. Six hundred million would be paid to Medi-Cal managed care plans, which they, in turn, would be required to pay to hospitals, with the specific amounts for individual hospitals being subject to negotiations between the plans and hospitals. Another $600 million would be used for the hospital services paid for in the Medi-Cal and Healthy Families program expansions.

Similarly, public hospitals would pay a new hospital fee, which would generate $600 million in the first year of implementation. The rate increase for public hospitals would be different than for private hospitals as the state already provides the maximum funding allowed under state law. The funds raised by the fee on public hospitals would be used as general funding for ABX1 1. The state would provide a Medi-Cal rate increase for public

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hospitals with state funds, using state funds in lieu of local funds as the state match. These funds would be matched with federal funds and then paid back to the hospitals, either directly or indirectly through increased payments from managed care plans and from payments for hospital services provided under the coverage expansions.

Comments and issues

1. Governor's budget contains provisions that could impact these proposals. The proposed budget would divert hospital funds, including DSH funds, to other purposes, thereby reducing hospital reimbursements. If these are adopted, these would reduce funds for coverage expansions or hospitals. The budget does contain a proposed Medi-Cal rate decrease, but hospital inpatient rates are exempt.

G. Individual contributions – section of the bill: 53

The fiscal analysis assumes that under ABX1 1 about $2.5 billion of the purchasing pool's $7.1 billion in costs at full implementation would come from employees and dependents who obtain coverage through the pool in the form of premium contributions. These contributions would vary as a function of income and with the choice of plan, and would represent a small percentage of the full cost of the coverage for lower income enrollees and a higher percentage of the cost for higher income enrollees.

H. Contingencies in event of funding shortfall - section of initiative: 5

Under the proposed initiative, twice annually the Director of Finance would be required to review the funds available, and projected to be available, to support the provisions of ABX1 1 and other information, as specified, and to determine whether the revenues are sufficient to fund the programs and provider rates established and expanded by ABX1 1 in the current fiscal year and in either of the two following fiscal years. If the Director determines that the funds are not sufficient, he or she would be required to so notify the Governor and the Legislature, including the Joint Legislative Budget Committee. If the Legislature does not pass legislation to address the fiscal imbalance within 180 days, several provisions contained in ABX1 1 would become inoperative, including the mandate to enroll in and maintain minimum creditable coverage, the requirements that health plans and insurers offer coverage without regard to medical status, the health insurance risk adjustment and reinsurance provisions that MRMIB and the Commissioner are required to develop to assist plans and insurers in managing risk in the individual insurance market, the tax credit administered by MRMIB, and the Medi-Cal eligibility expansions for adults. In addition, beginning on the January 1st which falls at least 270 days after the Director's notification, Medi-Cal rates for hospital services would revert to the rates that were in effect on June 30, 2010.

If the Legislature and Governor took no further steps to address the imbalance and these provisions were triggered, several provisions of the bill would remain in effect, including the purchasing pool, all of the assessments and taxes with the exception of the hospital fees, requirements pertaining to coverage tiers and rating restrictions in the individual insurance market, the children's coverage expansions, the Medi-Cal eligibility

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streamlining provisions, data collection and transparency provisions, and other health insurance regulatory reforms such as the medical loss ratio and prohibitions on rescission of health insurance contracts and policies.

Comments and issues

1. Some reductions could be done administratively or through the budget, others would require follow-up legislation. A number of elements of ABX1 1, including funding for community clinics and the diabetes, obesity, tobacco, and community makeover grant program provisions, provisions dealing with Medi-Cal rates for physician services, and the proposed specific tax credit for older residents, are subject to appropriation by the Legislature by the terms of ABX1 1 and could be reduced or eliminated through the budget process without triggering the process whereby major elements of the bill would be made inoperative. Together these elements may comprise some $800 million of the $14 billion in total expenditures for programs associated with the bill. In addition, MRMIB is given significant authority to alter the benefits and cost sharing requirements associated with the coverage provided through the purchasing pool in order to ensure the fiscal solvency of the pool and its changes could be implemented administratively, although it is not known how much in savings it could achieve using its administrative discretion. However, fundamental changes in the revenues and costs of the program over time (for example, if one or more financing elements in the proposed initiative were invalidated, or if revenues and costs grow disproportionately over time,) would likely require enactment of further legislation or would result in initiation of the process to make major provisions inoperative.

VI. Scope of Practice Changes - sections of bill: 3, 5

A. Supervision of medical assistants. Existing law authorizes medical assistants (MAs) to administer medication by intradermal, subcutaneous, or intramuscular methods, and to perform injections and perform skin tests and additional technical supportive services, upon the specific authorization and under the supervision of a licensed physician and surgeon or a licensed podiatrist. In the case of primary care clinics and specialty clinics, MAs may perform these duties upon the specific authorization of a physician assistant (PA), a nurse practitioner (NP), or a nurse-midwife. Existing law authorizes a supervising physician and surgeon at a primary care clinic to directly provide written instructions to be followed by an MA in the performance of such tasks or supportive services. Existing law also permits the written instructions from the supervising physician and surgeon, to allow supervision of an MA to be delegated to an NP, nurse-midwife, or PA, and allows the tasks to be performed by the MA when the supervising physician and surgeon is not at the primary care clinic or specialty clinic, under specified circumstances.

This bill would authorize an MA to perform these treatment activities under the authorization of an NP, a nurse-midwife, or a PA in any setting.

The bill would also establish a nine-member Task Force on Nurse Practitioner Scope of Practice, with specified membership, to develop a recommended scope of practice for

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NPs by June 30, 2009, and would require the Director of Consumer Affairs (DCA) to promulgate regulations, consistent with existing law, that adopt the Task Force's recommended scope of practice by July 1, 2012.

Comments and issues

1. Medical assistant supervision provisions are very broad. While current law allows medical assistants to work under the specific authorization of a physician assistant, nurse practitioner, or nurse-midwife in a primary care and specialty clinic, and allows the instructions of a physician, in a primary care clinic, to a medical assistant to provide for supervision of the assistant to be delegated to a nurse practitioner, physician assistant, or nurse-midwife, this bill would allow supervision of medical assistants by nurse practitioners, physician assistants, and nurse-midwives to occur in any facility or setting. This would allow such supervision to occur in medical offices, retail clinics such as those at local drug stores, and other unlicensed settings, where there would be no licensing oversight. By contrast, AB 859 (Bass, 2006) which was sponsored by the California Academy of Physician Assistants (CAPA), proposed that this extension be limited to licensed settings. *AB 859 failed passage in Assembly Business and Professions Committee.*

2. Nurse practitioner scope of practice provisions conflict with existing law. Under current law, the Board of Registered Nursing defines and interprets the practice of registered nursing, including practice by nurse practitioners. The task force created under this bill appears to conflict with the Nursing Practice Act, which reads, in part, "No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute." A Senate Business Professions and Economic Development (BPED) committee analysis of provisions similar to those contained in the bill states that it is the Legislature's prerogative to determine scope of practice for licensees under the Business and Professions Code. This provision should be amended to instead require Department of Consumer Affairs to recommend a legislative proposal for any changes to the scope of practice for nurse practitioners.

VII. Data Transparency and Pay-For-Performance Provisions – sections of bill 13, 32-33

The bill contains several provisions designed to expand reporting and public disclosure of health care cost, quality, and outcome data (Section A, below) and to link payments to providers to their performance on established quality indicators (Section B, below).

A. Data collection and transparency

The bill would establish a sixteen-member Health Care Cost and Quality Transparency Committee to develop and recommend to the Secretary a health care cost and quality transparency plan designed to provide public reporting of health care safety, quality, and cost information, and to monitor the implementation of the plan. The committee would be required to make its recommendations within one year of its first meeting and to

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review the plan at least once every three years. The bill would direct that the plan provide for collection of data from health plans and insurers, medical groups, health facilities, licensed physicians, and other health care professionals, and that it include a process for assessment of compliance with data collection requirements and a recommended fee schedule to fund its implementation. Within 60 days of receipt of the plan, the Secretary would be required to either accept the plan and develop regulations to implement it, or refer the plan back to the committee for further modifications. The Secretary would be directed to assure timely implementation of the plan, including determining the specific data to be collected, collecting the data, and providing an opportunity for providers who report data to review, comment on, and appeal any outcome report before it is released. The bill would require the Office of Statewide Health Planning and Development (OSHPD) to provide the Secretary with a proposed fee schedule to be paid by providers to establish and support implementation of the plan. Proposed fees would be subject to approval by the Legislature and Governor in the annual budget. Fees imposed on hospitals specifically would be capped at 0.006 percent of their operating costs, as specified. The bill would establish a special fund for fees and other contributions. The Secretary would be required to report to the Legislature every six years after implementation of the plan, and to include recommendations concerning continuation of the committee.

The bill would also require the Office of the Patient Advocate to provide public access to reports and data obtained by the lead agency.

The proposal would additionally require OSHPD, beginning January 1, 2010, to publish risk-adjusted outcome reports for percutaneous coronary interventions conducted in hospitals and to compare risk-adjusted outcomes by hospital and physician, and would establish a process for the appointment of physician panels to review and approve models used to prepare outcome reports on individual physicians.

Comments and issues

1. The bill caps fees to be paid by hospitals. Because fees supporting the committee as well as the expanded data collection and reporting called for in the bill are capped for hospitals, but not for other providers who would be subject to reporting requirements, other providers could be disproportionately assessed as a percent of the overall funding required to implement these provisions of the bill.

B. Pay-for-performance provisions.

ABX1 1 requires the California Health and Human Services Agency (CHHSA) to consult with CalPERS, and affected health provider groups, to develop performance benchmarks for quality measurement and reporting into a common "pay for performance" model to be offered in every state-administered health care program. The bill further would require that the benchmarks developed by CHHSA be advanced as a common statewide framework for quality measurement and improvement. The bill would also require DHCS to use pay for performance measures for awarding up to 25 percent of the Medi-Cal physician rate increase.

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Comments and issues

1. Does the process envisioned in ABX1 1 promote better outcomes for patients? Opponents to this provision have raised the issue that granting CHHSA and CalPERS, one of the largest purchasers of health coverage in the country, broad discretion to adopt a pay for performance program could have the unintended consequence of creating a disincentive to treat those who are hardest to care for.

2. There are concerns that pay for performance will harm those physicians who treat patients with lower socioeconomic status. Although the bill requires DHCS to consult with various stake holders in developing guidelines for pay for performance measures, there is no indication that they should attempt to recognize pay for performance difficulties based on larger clinical and socioeconomic factors such as poverty, English as a second language and mental health. Opponents remain concerned that there may not be such an adjustment mechanism and, if there is that it may not adequately take into account the actual difficulties and costs of treating these patients. In other pay for performance programs, physicians who treat those more difficult to care for are often penalized because they may be less likely to meet designated goals.

VIII. Other provisions

A. Hospital and physician rates - sections of bill: 72, 76, 77

The bill would require Medi-Cal to pay private and special district hospitals the maximum allowed under federal law. The payments would be adjusted annually by a cost escalator. As noted earlier, the increased funds for the Medi-Cal rate increase would be generated by a fee on hospitals. The collected fee would be matched with federal funds and paid back to hospitals in the form of a Medi-Cal rate increase. The hospitals would get a direct increase in rates for inpatient and outpatient fee-for-service Medi-Cal. In addition, Medi-Cal managed care plans would be paid more for the hospital services of those they cover, but the entire amount must be passed through to hospitals with the specific amounts subject to negotiation between the plans and the hospitals. Hospitals will also see increased revenues through the hospital component of the coverage expansion programs.

For physicians, the amount of the rate increase is not specified. Instead, the bill's provisions would allow reimbursement to be established at a percentage of the amount paid by Medicare for the same services. The bill would also prohibit any reduction in Medi-Cal rates for physician services that are currently paid at or above the Medicare reimbursement rate. The amount of the increase in physician rates would be subject to appropriation in the annual state budget and would require obtaining federal matching funds. As indicated in the previous section of the analysis, the bill would allow DHCS to set aside as much as 25 percent of the rate increase to be paid based on pay for performance measures. A recent study by the Urban Institute showed that California's Medi-Cal payments to physicians average only 59 percent of Medicare rates for similar services, which is below the national Medicaid average of 69 percent. Other studies have

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found that low payment rates contribute to low rates of physician participation in Medi-Cal.

Comments and issues

1. The Governors' proposed 2008-2009 budget contains rate cuts for Medi-Cal providers. Hospital inpatient services were exempted from rate cuts in the Governor's proposed budget, but supplemental funds used to pay for the uncompensated costs of treating Medi-Cal patients and the uninsured were proposed to be cut, as well as outpatient payments. If these cuts were to be adopted**,** the gap between what hospitals are paid now and what they are required to be paid by ABX1 1 would increase. Because the modeling assumes that, under ABX1 1, physicians' rates would be increased to 70 percent of Medicare, there would be a gap that would need to be made up if that goal is to be achieved. In the near term, the reduction in rates contained in the proposed budget would exacerbate the continuing problem of physician participation in the Medi-Cal program which would also apply to the coverage expansions proposed in ABX1 1. Adjusting for this problem would require an additional cost for the program proposed in ABX1 1.

2. Physician rate increases are left up to future legislation. ABX1 1 would require that any increase in payments to physicians would occur only if an appropriation was made in the annual budget act.

B. IHSS worker provisions - section of bill: 60

Existing law establishes the In-Home Supportive Services (IHSS) program under which counties arrange and provide for specified services for approximately 400,000 aged, blind, and disabled persons who are otherwise at risk of being placed in a nursing home or other institution if they did not receive IHSS services. Federal (Medicaid), state and county funds are used to finance the current system which is projected to cost approximately $4 billion next fiscal year or, on average, a cost of $10,000 per recipient.

The current IHSS program provides: (1) domestic services, such as housework, shopping for groceries and meal preparation; (2) non-medical personal care services, such as toileting, dressing, transportation; (3) paramedical services, such as giving medications and changing a colostomy bag; and, (4) protective supervision for those who, due to cognitive decline or dementia, cannot be left alone for extended periods.. The federal government finances approximately half of these costs and the state and counties share in the remaining half of the cost using a formula of 65 percent state and 35 percent county funding. The federal government has approved these programs because of the savings accruing both to the state and to the federal government by keeping these patients out of institutions.

ABX1 1 increases the state funds that can be used to pay for IHSS workers' health benefits by the county or public authority, which are entities established to administer portions of the IHSS program in some counties. Currently, the state provides its share of funding, 65 percent, of the statutorily allowed $12.10 per hour in wages and $.60 in

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benefits. The increases would be sequential, with two of the three proposed increases conditioned upon a specified increase in the state's general fund. The first increase would raise the benefits that the state would share in paying to $.85, the second increase would increase benefits to $1.10 and the third to $1.35. ABX1 1 also provides that, if the employee representative chooses, health care benefits can be provided through a trust fund and the county or public authority must abide by that decision.

Comments and issues

1. IHSS provisions affect counties and safety net hospitals. Increasing funding for benefits for IHSS workers would increase both state and county costs, assuming most counties make the benefit adjustments**.** The fiscal impact assessment for ABX1 1 assumes the cost to the state in the first full year of implementation would be $21 million, and that these costs would likely increase in the second and third stage increases provided by the bill. County costs are unknown. Currently some counties provide benefits to IHSS workers with a plan that is centered on the county hospital. To the extent that health benefits are increased for IHSS workers, this could be a benefit to the county by increasing the coverage in the plan and reducing uncompensated costs at the hospital. However, to the extent that trusts contract with providers other than the county, this could have a negative impact.

2. Language regarding trusts is unclear. ABX1 1 does not provide any reference or requirements as to the type and structure of trust fund that would be used for providing benefits. Proponents state that it would be a Taft-Hartley trust which is created in federal law so that private sector unionized employees can get health and other benefits. Most Taft-Hartley trusts are structured in a way that makes them subject to ERISA regulation. A basic characteristic of a Taft-Hartley trust is that the fund and its assets are managed by a joint board of trustees equally representative of management and labor. Such a board is not specifically provided for in ABX1 1. In addition, these trusts are not subject to regulation as health plans or insurers in California.

C. Electronic prescribing - sections of bill: 7-10, 23, 34

Existing law makes it a crime for healing arts practitioners to engage in or receive consideration for activities associated with the referral of patients. Existing law exempts from this restriction the provision, in certain cases, of non-monetary remuneration in the form of hardware, software, information technology and training services used solely to receive and transmit electronic prescription information, as specified. The bill would permit Medi-Cal managed care organizations to provide hardware, software, or information technology, as well as the training necessary to receive and transmit e-prescription information, to pharmacists and in-network pharmacies.

Existing pharmacy law defines "prescription" as an oral, written, or electronic transmission order, meeting specified requirements. This bill would define "e-prescribing" as a prescription , or prescription-related information, transmitted between the point of care and the pharmacy, using electronic media.

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The bill would require every licensed prescriber or pharmacy to have the ability to transmit and receive e-prescriptions by January 1, 2012, and would give the State Board of Pharmacy and other specified licensing boards authority to ensure compliance. The bill would prohibit e-prescribing from interfering with a patient's existing freedom to choose a pharmacy or with a prescribing decision at the point of care, and would additionally require prescribers to offer patients a written receipt that includes specified information.

E-prescription systems would be required either to comply with national standards for data exchange or be accredited; to allow real-time verification of an individual's eligibility for benefits; to comply with state and federal confidentiality and data security requirements; and to comply with state record retention and reporting requirements.

The bill would require DHCS to identify best practices related to e-prescribing, to make recommendations for statewide adoption of e-prescribing by January 1, 2009, and to develop a pilot program to foster the adoption and use of e-prescribing by health care providers who contract with Medi-Cal, contingent upon the availability of federal funding. The bill would also permit DHCS to provide e-prescribing technology to participating Medi-Cal providers, and require health plans and insurers to make the most current prescription drug formularies available electronically to prescribers and pharmacies.

Comments and issues

1. Potential impacts on providers and pharmacies. A Senate Business Professions and Economic Development Committee analysis of similar provisions in an earlier proposal notes that requiring real time verification of benefits and coverage will likely increase providers' hardware, software, and information technology maintenance costs.

D. Electronic health records - sections of bill: 15, 44

Existing law, under the federal Health Insurance Portability and Accountability Act (HIPAA), sets forth national standards and requirements for the transmission, storage, and handling of certain electronic health care data. This bill would require, by January 1, 2010, CalPERS to provide an electronic personal health record (PHR) for enrollees. Electronic PHRs would be required to provide, at a minimum, access to real-time, patient-specific information regarding benefit eligibility and cost sharing requirements, but would permit records to incorporate additional data at the option of the enrollee.

The bill would also permit MRMIB to provide or arrange for the provision of electronic PHRs for Healthy Families enrollees, to the extent that funds are appropriated for this purpose. The bill would permit access to be provided through a web-based system and would specify additional information that MRMIB may require to be included in the electronic record, at the option of the enrollee.

The systems developed by CalPERS and MRMIB would be required to adhere to national standards for interoperability, privacy, and data exchange, or to be certified by a

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nationally recognized certification body and to comply with applicable state and federal confidentiality and data security requirements.

E. Healthy Actions and incentive rewards - sections of bill: 16, 28.5, 37, 42, 57, 74

Existing law requires, by regulation, health plans to cover basic health care services and medically necessary services, as defined. The bill would, effective January 1, 2009, require every health care service plan and every policy of health insurance, except for a Medicare supplement plan, that covers hospital, medical, or surgical expenses on a group or individual basis to offer to include a Healthy Action Incentives and Rewards Program (Healthy Actions program), as defined, in connection with a health care service plan or insurance policy, in the case of a group policy, under the terms and conditions agreed upon between the group and the health plan or insurer. The bill would require health plans and insurers to communicate the availability of the program to all prospective groups with whom they are negotiating and to existing groups upon renewal.
The bill would require all Healthy Actions programs approved by the DMHC director and the Insurance Commissioner to be offered and priced consistently across all groups, potential groups, and individuals and to be offered and priced without regard to the health status, prior claims experience, or risk profile of the members of a group or individual. The bill would prohibit a plan or insurer from conditioning the offer, delivery, or renewal of a contract that covers hospital, medical, or surgical expenses, on the group's purchase, acceptance, or enrollment in a Healthy Actions program. The bill would also prohibit rewards and incentives from being designed, provided, or withheld based on the actual health service utilization or health care claims experience of the group, members of the group, or the individual.

The bill would require health plans to file the program description and design as an amendment to its application for licensure and would require insurers to file the same information with the Insurance Commissioner in order to demonstrate compliance with these requirements. The bill would also require the DMHC director or Insurance Commissioner to disapprove, suspend, or withdraw any product or program developed if it is determined that the product or product design has the effect of allowing health care service plans to market, sell, or price health coverage for healthier lower risk profile groups in a preferential manner that is inconsistent with current law.

The bill would require CalPERS to provide a Healthy Actions program to its enrollees by January 1, 2010, and would require DHCS to establish a Healthy Actions program as a covered benefit under Medi-Cal only to the extent that federal financial participation is obtained. The bill would require DHCS to secure federal financial participation and all federal approvals necessary to implement and fund Medi-Cal Healthy Actions program services.

The bill would require that any Healthy Actions program include health risk appraisals, access to an appropriate health care provider to review the results of the appraisals, and incentives or rewards for enrollees to become more engaged in their health care and to make appropriate choices that support good health. The bill would permit incentives and rewards to include, but not be limited to, health premium reductions, differential co-

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payment or coinsurance amounts, cash payments, nonprescription pharmacy products or services, exercise classes, gym memberships, and weight management programs. The bill would also prohibit Healthy Actions program requirements from replacing any other requirements that plans or insurers provide health care screening services, childhood or adult immunizations, and preventive health care services.

Employers would be permitted to provide health coverage that includes a Healthy Actions program that meets the above requirements and permit an employer-offered program to include monetary incentives and premium cost reductions for nonsmokers and for smoking cessation activities.

Comments and issues

1. ***No CHBRP analysis of benefit mandates in program.*** AB 1996 (Thomson – Chapter 795, Statutes of 2002) and SB 1704 (Kuehl – Chapter 684, Statutes of 2006) require that the California Health Benefits Review Program (CHBRP), together, provide an independent analysis of the medical, financial, and public health impacts of legislation proposing to mandate or repeal a health plan or insurance benefit or service. This bill seems to mandate a number of benefits by requiring an offer to include a Healthy Actions program in health plan and insurance products. However, there has not been a CHBRP analysis conducted consistent with current law.

F. Diabetes, obesity and smoking provisions – sections of bill: 29, 30, 75

1. California Diabetes Program and Diabetes Services Program

Existing law gives DPH broad authority to protect, preserve, and advance public health. Under these provisions, DPH established the California Diabetes Program (CDP) in 1981, which receives grants from the federal Centers for Disease Control and Prevention. For the current federal fiscal year, the grant is $1.199 million. The state currently provides no funding for this program.

The bill would require DPH to maintain the CDP, only to the extent that state funds are appropriated, to provide information on diabetes prevention and management to the public, as well as technical assistance to the Medi-Cal program regarding the scope of benefits under a new Comprehensive Diabetes Services Program (CDSP), which would be established under the bill. The CDSP would provide diabetes prevention and management services to fee-for-service Medi-Cal enrollees who have pre-diabetes or diabetes, are between 18 and 64 years of age and who are not dually enrolled in Medi-Cal and Medicare. The bill would require DHCS to develop and implement incentives for Medi-Cal fee-for-service eligible beneficiaries and providers.

The bill would require DHCS to collect specified data to monitor the health outcomes of participating Medi-Cal beneficiaries. The bill would also require DHCS, in consultation with CDP, to contract with an independent organization to report on health outcomes and cost savings, and estimate the short- and long-term cost savings of expanding CDSP to private or commercial insurance markets.

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The bill would require DHCS to secure all federal approvals to implement and fund CDSP services and would permit the program to be implemented only to the extent that federal financial participation has been obtained.

2. Smoking cessation

Existing law imposes various responsibilities and duties on the DPH relating to tobacco use and prevention programs, including administering funding for programs relating to smoking cessation, such as the California Smokers' Helpline. Each year, about $67 million of cigarette surtax revenue is transferred to the Health Education Account (HEA) to support tobacco use control programs at DPH and the California Department of Education.

This bill would require DPH, in consultation with DMHC, DHCS, MRMIB, and DOI, to annually identify smoking cessation benefits provided by the ten largest public and private providers of health care coverage and to make this information available on its website. This bill would also require DPH to include smoking cessation benefit information as part of its educational efforts to prevent tobacco use.

The bill would require DPH, to the extent funds are made available, to increase the capacity of the California Smokers' Helpline and to expand public awareness about the helpline and other existing cessation benefits. DPH would be required to evaluate changes in awareness concerning the availability of cessation benefits by beneficiaries and health care providers, changes in utilization rates of these benefits, smoking-related indicators, changes to smoking cessation benefit coverage, and the impact on smoking rates resulting from the expansion of the helpline.

Comments and issues

1. Previous smoking cessation legislation. The bill's provisions related to the collection of information on smoking cessation benefits offered by plans and insurers do not go as far as other bills that have been considered by the Legislature, which have required plans to offer benefits. SB 576 (Ortiz) of 2006 would have required health plans and health insurers to provide coverage for two courses of tobacco cessation treatments per year, including counseling and prescription and over-the-counter medications, and would have prohibited plans and insurers from applying deductibles but allow specified co-payments for those benefits, an approach that research has shown to be more effective. *This bill was vetoed by Governor Schwarzenegger*.

G. Community makeover grants - section of bill: 31

The bill would, contingent upon an appropriation, create the Community Makeover Grant program, under which grants would be awarded by DPH to local health departments. According to the author and the administration, base funding for each local health department would be $200,000 ($12 million total). An additional $12 million would be distributed on a per capita basis, to be expended for specified purposes related to active living and healthy eating. DPH would be required to issue guidelines for local health

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departments on how to prepare a local plan to promote active living and healthy eating in order to prevent obesity and other related chronic diseases.

Existing law requires the DPH to develop a comprehensive strategic plan that assesses California's current programs and efforts in obesity prevention, identifies core gaps or concerns, identifies best practices, and makes recommendations for improvement, called the California Obesity Prevention Plan. Under this bill, DPH would be required to track and evaluate obesity-related measures, as specified, to direct the most efficient allocation of resources for obesity prevention, and to measure the extent to which funded programs promote the goals identified in the California Obesity Prevention Plan.

The bill would also require DPH, to the extent funds are appropriated, to develop a public education campaign regarding the importance of obesity prevention that frames active living and healthy eating as "California living," in accessible and culturally and linguistically appropriate formats. DPH would be required to provide assistance and support for schools to promote the availability and consumption of fresh fruits and vegetables and foods with whole grains, and also to provide technical assistance to help employers integrate wellness policies and programs into employee benefit plans and worksites.

H. Prohibition on hospital balance billing - section of bill: 18

Existing law requires health plans to reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, and provides that health plans are liable for the reasonable charges by non-contracting hospitals, as well as treating physicians, for emergency services provided to health plan enrollees. Existing law prohibits contracting providers from billing enrollees for the portion of their customary charge that is not paid by health plans, other than any applicable co-payments, coinsurance, or deductibles, but contains no similar prohibition for non-contracting providers.

This bill would prohibit a non-contracting hospital, as defined, from billing a covered patient for non-emergency health care services and post-stabilization care, except for applicable co-payments and cost shares. The bill does not change the law relating to non-contracting treating physicians, who may continue to bill patients for the difference.

I. Public insurer - sections of bill: 17, 20

The bill would establish the California Health Benefits Service (CHBS) for the purpose of expanding public coverage options. The CHBS would be required, by January 1, 2009, to identify and report to the Legislature on barriers relating to the establishment and maintenance of joint ventures between health plans that contract with, or are governed, owned, or operated by, a county, county special commission, county organized health system, or a county health authority. The report would also be required to identify barriers that may inhibit the expansion of services by existing local health plans or by the County Medical Services Program (CMSP) into counties where there is not a local health

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initiative or county organized health plan, or that would inhibit the CMSP from participating in joint ventures.

The bill would require the CHBS to provide technical assistance to local health care delivery entities, such as local health initiatives or county organized health systems, to support joint ventures and other efforts to expand services to other geographic areas and populations. The CHBS would also provide local health care delivery entities technical assistance to contract with providers to provide health care services in counties where there is not a local initiative or county organized health plan that contracts with the state or that opts to participate in such joint ventures. The bill would authorize the DHCS to enter into contracts with joint ventures to provide medical services to specified populations.

The bill would authorize local health plans to form joint ventures to create integrated networks of public health plans that pool risk and share networks, and in doing so, would require participating health plans to seek contracts with public hospitals, county health clinics, and community clinics. All joint ventures and health care networks would be required to seek licensure as a health care service plan pursuant to the Knox-Keene Act.

The bill would establish a Program Stakeholder Committee, within the CHBS, comprised of ten members appointed by the DHCS director, the Senate Rules Committee, and the Speaker, who represent specified stakeholders including local health initiatives, county organized health systems, organized labor, and health care purchasers, consumers and providers, to provide input and assistance with the implementation of CHBS responsibilities. DHCS would be required, by November 1, 2009, to report and make recommendations to the Senate and the Assembly on the implementation and progress of the CHBS.

J. Workforce development – section of bill: 76

ABX1 1 would require a portion of the payments for public hospitals to be set aside in a special fund for workforce development. Monies in the fund would be subject to legislative appropriation and used for retraining the health care workers in county hospital and clinic systems. The Office of Statewide Health Planning and Development (OSHPD) would administer the fund and make allocations from the fund to counties. Proponents argue that, with the Medi-Cal rate increase, public hospitals will face stronger competitive pressures and this training will help them retain their viability in a more competitive market.

K. Evaluation - section of bill: 14

The proposal would require the Secretary, in collaboration with other relevant state agencies and an advisory body, as specified, to track and assess the effects of health care reform, including assessments of the sustainability and solvency of the pool, the cost, access, availability, and affordability of health care, the health care coverage market, the effect on employers and employment, the county health care safety net system, and the

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capacity of various health care professions. The Secretary would be required to submit the assessment to the Legislature by March 1, 2012, and update it, biennially, thereafter.

L. Non-severability - section of bill: 84.5

The bill provides that its provisions are non-severable, meaning that if any provision of the bill is held to be invalid, all provisions of the bill would become inoperative.

FISCAL IMPACT

According to a fiscal analysis prepared by the administration, total costs of the various coverage provisions, rate increases, public health initiatives, and administrative requirements associated with ABX1 1 would be approximately $14.9 billion in total funds in the first full year of implementation, in 2007 dollars. These costs would increase at varying rates between the effective date of the bill and the date of full implementation. Among the more significant costs of the proposal would be $7.1 billion for the coverage provided by the purchasing pool, $2.4 billion for the proposed Medi-Cal and Healthy Families eligibility expansions, $3.8 billion for the proposed Medi-Cal rate increases for hospitals and physicians, $465 million for the proposed tax credits for employees and early retirees, about $300 million for the various public health initiatives, and about $540 million for administration, including net payments associated with the automatic enrollment provisions for persons who do not comply with the mandate to maintain minimum creditable coverage. These costs are summarized in the chart below.

According to the fiscal analysis, these costs would be offset by approximately $15.1 billion in revenues and cost savings in the first full year of implementation. The analysis assumes payments by employers choosing to pay health care contributions would total $1.6 billion; another $940 million would come from employer contributions towards the costs of public programs for employees who are eligible for public programs. Individual contributions in the form of premium payments for coverage through the purchasing pool would produce another $2.5 billion. Other revenue sources would include federal funds ($4.4 billion), redirected county funds ($1 billion), hospital assessments ($2.5 billion), tobacco tax revenues ($1.5 billion), and savings from reduced utilization of other health programs ($727 million).

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ABX1 1 Fiscal Impact Summary

(Dollars in Millions)

Costs	**Full Implementation**
Purchasing Pool	$7,130
Medi-Cal and Healthy Families Expansion	$2,434
Tax Credit 250-400%	$415
Additional Tax Credit for Early Retirees	$50
Expanded Access to Primary Care Funding Increase	$140
Diabetes/Healthy Actions	$100
Obesity/Tobacco	$63
Section 125 Tax Treatment	$235
Seamless Enrollment	$114
Medi-Cal Rate Increases	$3,793
In-Home Supportive Services Health Benefits	$21
State Administration Costs	$427
Total Costs	**$14,922**

Revenues and Other Funding	**Full Implementation**
Employer Fee	$1,630
Employer - Horizontal Equity	$940
Hospital Fee	$2,504
Individual Contributions	$2,460
Federal Funds	$4,368
County Funds and Program Savings	$1,727
Tobacco Tax Increase	$1,463
Total Revenue	**$15,092**

Difference	**$170**

These costs are approximately $500 million higher than those estimated in the Assembly Appropriations Committee analysis, most of which, according to administration representatives, is accounted for by adjustments to the assumed costs of coverage in the purchasing pool and higher assumed costs for Medi-Cal managed care payment rates.

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BACKGROUND AND DISCUSSION

A. Author's Purpose

According to the author, ABX1 1, and a companion statewide ballot initiative anticipated for the November 2008 ballot, represent comprehensive and sweeping reforms to California's ailing health care system. The author states that the bill would significantly reduce the numbers of the uninsured through public program expansions and increased employer participation in the health care of workers; organize and improve the health insurance market for individuals; advance innovative strategies to reduce health care costs and improve quality; and protect California's budget through dedicated revenues that make the proposal self-financing. The author states that, once the bill is fully implemented, approximately 70 percent of California's 5.1 million uninsured, most of who are low-income working individuals and their families, including 800,000 children, will no longer be uninsured for health care.

The author states that, by covering many of the uninsured, this bill would reduce the existing cost shift to the insured of uncompensated health care costs, which raises health care costs, health insurance premiums and the costs of government health care programs. The author asserts that the bill would bring in $4.6 billion in new federal funds that would help pay for the public program expansions, Medi-Cal physician rate increases, and, combined, with the over $2.3 billion in additional revenues generated by the proposed hospital fee, Medi-Cal hospital rate increases. The author states that raising Medi-Cal rates is another strategy to improve access to health care and to reduce cost shifting to private purchasers, individual consumers, and employers.

B. Background

The health care system has been engaged in a downward spiral caused by rising costs and declining coverage. According to data compiled by the California Healthcare Foundation, health care spending in California reached a new high of $169 billion in 2004, or 11 percent of the state's economy. Health care spending has increased at an average of 8 percent between 1980 and 2004, over twice the rate of economic growth during that same time period. Current projections indicate that health care spending could exceed 20 percent of the gross national product by 2025.

Between 1999 and 2005, premiums for employer provided health insurance in California increased by 97 percent, while the general cost of living increased by "only" 24 percent. Average premium increases in California in 2006 (8.7 percent) were more than twice the California inflation rate of 4.2 percent, and higher than the national increase rate of 7.7 percent. At the same time, of employers offering any kind of health insurance coverage, over one-third of employers overall, and nearly half of employers with less than 200 employees, experienced premium increases of over 10 percent.

According to the UCLA Center for Health Policy Research, over 20 percent (20.2) of the non-elderly population, roughly 6.5 million residents, lacked health insurance coverage in

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2005. The percentage of the non-elderly population with employer sponsored coverage declined from 56.4 percent to 54.3 percent between 2001 and 2005, while the percentage with Medi-Cal or Healthy Families coverage increased from 13.7 percent to 15.8 percent during the same time period.

According to a recent survey by the Kaiser Family Foundation, one in four Americans say their family had a problem paying for health care sometime during the past year, and 28 percent say someone in their family has delayed seeking health care in the past year. Studies show that, compared to persons with health insurance, people without health insurance are more apt to postpone seeking care because of cost, more apt to fail to fill prescriptions due to cost, more apt not to receive preventive care, and more apt to have trouble paying medical bills. Because they are uninsured, reports show that individuals are often billed for hospital care at the hospital's full charges, which are typically three to four times higher than the costs paid by insurance plans. A recent study by Harvard researchers found that nearly half of all personal bankruptcies in the U.S. are due to medical expenses and three-fourths of those patients had health insurance.

According to a study by the New America Foundation, cost shifting by health care providers, related to treating the uninsured, accounted for 10 percent of the cost of health insurance premiums in California, roughly $455 annually for an individual policy and $1,186 for a family coverage policy.

C. Proposal Incorporates Elements of "Massachusetts Plan" (Act)

In 2006, Massachusetts enacted legislation requiring all residents to be covered by some sort of health insurance. The Act requires all residents who are 18 years of age or older to have health insurance, if coverage is "affordable," a term not defined in the statute. The Act requires employers with more than 10 employees to make a "fair and reasonable" contribution towards employee health coverage or pay an assessment to the state of up to $295 per worker, per year. The Act implemented a number of Medicaid reforms, including expanding eligibility for children in the state's Medicaid program from 200 to 300 percent of the federal poverty level and increasing payment rates for Medicaid providers. Funding sources for the Act include state funds, federal funds, a previously existing assessment on hospitals and payers for the uncompensated care pool, as well as the $295 per worker, per year, assessment on employers who do not contribute to employee coverage.

In addition, the Act establishes a state purchasing pool known as the "Connector" to provide coverage options for persons without access to employer-provided coverage and employers with 50 or fewer workers, including low-cost products specifically for 19 - 26 year olds. The Connector is also charged with determining if coverage is affordable for families with various levels of income and defining the minimum level of coverage required to meet the mandate. In order to facilitate the purchase of affordable health insurance products, the Connector operates two programs: Commonwealth Care, for uninsured individual adults with incomes below 300 percent of the FPL who do not otherwise qualify for MassHealth (the state's version of Medicaid and the State Children's Health Insurance Program), other public assistance programs, or have

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employer sponsored coverage; and Commonwealth Choice, for individuals and families who are not eligible for subsidized coverage.

Finally, the law merges the individual and small group insurance markets and applies modified community rating requirements for the combined market.

A key part of this reform is the definition of affordable coverage, which is revised annually by the Connector's board to determine who is subject to the mandate. The affordability schedule is designed to allow people to purchase coverage that meets the minimum creditable coverage, without spending more than between 5 and 10 percent of their income, or otherwise be exempted from the individual mandate. Minimum creditable coverage is defined in all plans but young adult plans as prescription drug coverage; visits to the doctor for preventative care before a deductible; deductibles that are capped at $2,000 for an individual or $4,000 for a family each year; an annual cap on out-of-pocket spending at $5,000 for an individual or $10,000 for a family for plans with up-front-deductibles or co-insurance; no cap on total benefits for a particular sickness or for a single year; and no cap on payment toward a day in the hospital. The affordability schedule currently ranges between 5 percent of income for individuals and families earning around 300 percent of the FPL, and 10 percent of income for individuals earning up to $50,000, and families earning up to $110,000. The affordability schedule refers to premium costs only and does not include out-of-pocket expenses, such as deductibles or co-payments.

For 2007, under the Massachusetts ACT, individuals earning above $50,000, couples earning above $80,000, and families earning above $110,000 (which correlates to between 500-600 percent of the FPL) are deemed able to purchase insurance, no matter the cost. For people earning between 300% and the upper income limits noted above, affordable coverage is based on a sliding scale of $150 to $300 per month for individuals, $270 to $500 per month for couples, and $320 to $720 per month for families. For people earning between 150% and 300% of the FPL, affordable coverage is based on a sliding scale of $35 to $105 per month for individuals, and $70 to $210 per month for couples and families. For people earning below 150% of the FPL, no premium is paid, according to the affordability scale.

Individuals who cannot find a health insurance product at or below the maximum affordable cost for their income bracket, or who face hardship, as defined in regulation, may file an exemption to the individual mandate through Schedule HC, which is required with the 2007 tax return. Individuals filing for a hardship exemption may also file a request for certificate of exemption to the Connector prior to the deadline for filing taxes. The Connector indicates that very few certificates of exemption have been processed and will not have an estimate for exempt or noncompliant individuals until after the 2007 tax filing deadline. Previously, the Connector had estimated roughly 60,000 people might be exempted under the current affordability standard. None of these exemptions will include individuals who qualify for subsidized coverage through Commonwealth Care or MassHealth, as health care coverage is provided at a rate corresponding to the affordability schedule.

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The Massachusetts Department of Revenue is responsible for imposing penalties for noncompliance with the individual mandate. For 2007, the penalty is the loss of the personal exemption worth $219 on an individual's state tax return. The Department of Revenue recently issued draft guidelines on 2008 penalties, which will be based on one-half of the lowest cost plans available through the Connector as of January 1, 2008, or from zero to $912 for an entire year without coverage.

Implementation Issues

The Massachusetts plan's individual mandate took effect on July 1, 2007, with a six-month extension for residents to obtain coverage without facing penalties. The state estimates that, in 2007, at least 300,000 people enrolled in health insurance, either through MassHealth (70,000); Commonwealth Care (160,000); Commonwealth Choice (16,000); or private carriers (75,000). The state estimates that somewhere between 50 percent and 75 percent of the uninsured have gained health insurance in the 18-month period between July 1, 2006 and December 31, 2007.

As the Act continues its second year of implementation, questions remain as to the sustainability of its funding and its enforcement of the individual mandate. While the state has seen better than expected enrollment numbers in its Commonwealth Care program, far exceeding its estimate of 136,000 enrollees by the end of the fiscal year (June 30, 2008), the result has been a $147 million funding gap for the state.

Additionally, while costs per enrollee have been largely within budget per enrollee this year, with just a four percent increase since the program began in October 2006, increases in proposed rates for Connector plans for the fiscal year beginning July, 2008 average 14 percent. The Connector believes a number of factors contribute to this, including competitive pressures on plans to underbid in the first year and the fact that relatively older and sicker residents sought coverage first, before the mandate took effect, while those who are younger and healthier chose to delay. In order to mitigate this increase, the Connector is currently considering additional cost-sharing, such as increasing the co-pay to $15, specialist co-pay to $25, and emergency visit co-pay to $75, for plan types serving upper income individuals.

Additionally, in order to constrain premium growth in the next fiscal year for the Commonwealth Choice market which has seen reductions of eight percent to increases of 13 percent, the Connector has asked carriers to voluntarily focus on a target of no more than five percent for premium increases, and has asked plans to submit both plan options that maintain benefits, but at a higher increase, and those that meet the target of five percent growth through tighter care management, lower provider reimbursements, use of limited networks, and increased cost sharing.

These increases come amidst the backdrop of the group market, which forecasters predict will see another rate hike averaging 10 percent. However, in the nongroup market, which now includes small group and individuals, the Connector states that prices for the non-group have fallen by 50 percent, while benefits have doubled. Additionally, the state has constrained the cost variance between the oldest and youngest individuals to a ratio of

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two to one, which makes coverage in the individual market relatively affordable for older persons.

Employer compliance also remains unknown. Initial estimates based on information submitted by the 50 percent of employers who met a 2007 reporting requirement suggest that of the 19,056 employers subject to the Fair Share Contribution requirement, 18,538 met the requirement while the remaining 518 firms owed the state $5.01 million in alternative assessments. In total, the state assumed it would receive $24 million in alternative assessments. In addition, because of the lack of reporting by many employers, it is not known how many are complying with the Fair Share requirement, or planning to pay assessments.

D. Related legislation

AB 8 (Núñez) would have required employers to spend 7.5 percent of Social Security wages on health care expenditures for full-time and part-time workers and their dependents, or pay an equivalent fee to a newly created California Health Care Trust Fund. The bill would have created a state purchasing pool to provide health coverage to employees of employers who opt to pay into the Fund. The bill would have required employees whose employers opt to pay into the Fund to enroll in Cal-CHIPP, unless they demonstrate coverage through other means, or meet financial criteria, as specified, and would also have required employees whose employers elect to make health expenditures to accept the services or coverage offered to them, unless they meet financial criteria, as specified. The bill would have expanded eligibility for Medi-Cal and Healthy Families coverage for low-income children and parents, and established various health cost containment measures and insurance market reforms. *This bill was vetoed by the governor. In his veto message, the governor stated that AB 8 does not achieve coverage for all, which is necessary to reduce health care costs for everyone, and that comprehensive reform cannot place the majority of the financial burden on any one segment of the economy or leave individuals vulnerable to loss or denial of coverage.*

ABX1 2 (No Author) contains the language from Governor Schwarzenegger's health care reform proposal. The bill would require all California residents to carry a minimum level of health insurance coverage for themselves as well as for their dependents, and would establish a state purchasing pool through which qualifying individuals would be allowed to obtain subsidized or unsubsidized health care coverage. The bill would expand eligibility for the Medi-Cal and Healthy Families programs, and increase Medi-Cal provider rates for hospitals and physician services. The bill would require health plans and insurers to offer and renew, on a guaranteed basis, individual coverage in five designated coverage categories, regardless of the age, health status, or claims experience of applicants, and establish new, modified community rating rules for the pricing of individual coverage. The bill contains provisions intended to reduce or offset a portion of the costs of health insurance coverage, as well as several new programs and initiatives related to prevention and promotion of health and wellness, and expresses intent that financing for the bill's provisions shall come from a variety of sources, including federal funds related to Medi-Cal and Healthy Families program expansions, fees from employers who do not offer health insurance coverage to their employees, revenues from

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counties, fees paid by acute care hospitals, premium payments from individuals, and funds from the lease of the State Lottery. The bill would make implementation of its provisions contingent upon a finding by the Director of Finance that sufficient state resources are available to implement the provisions. *This bill is currently in the Assembly Health Committee.*

SB 48 (Perata – as amended May 16, 2007) contained provisions similar to AB 8, but also contained a mandate for taxpayers with incomes above 400 percent of the FPL to maintain a minimum level of coverage. *These provisions were subsequently amended out of the bill.*

SB 840 (Kuehl) would establish a single-payer universal health care system that provides all California residents with comprehensive health insurance including a choice of doctors and hospitals. The bill would consolidate federal, state, and local monies currently being spent on health care services into a health care trust fund, and would require employers to contribute a percentage of payroll toward employee health care costs and individuals to contribute a percentage of income into the health care trust fund; these contributions would replace premiums now paid to insurance companies. The bill would contain long-term growth in health care spending through savings on administrative overhead, increased emphasis on preventive, primary, and chronic care, and using statewide purchasing power to negotiate discounts on drugs and durable medical equipment. *This bill is currently in the Assembly Appropriations Committee.*

SB 32 (Steinberg) and AB 1 (Laird) would expand eligibility for Healthy Families to children with family incomes at or below 300 percent of the FPL and would delete the specified citizenship and immigration status requirements for children to be eligible for Medi-Cal and Healthy Families. The bill would also allow applicants to self-certify their income and assets for the purposes of establishing eligibility for Healthy Families, and would establish a Medi-Cal presumptive eligibility program, as specified. *Both bills are currently on the Assembly inactive file.*

SB 365 (McClintock) and SBX1 16 (McClintock) would have allowed a health care service plan or health insurance carrier domiciled in another state to offer, sell, or renew a health care service plan or a health insurance policy in this state without holding a license issued by the Department of Managed Health Care (DMHC), or a certificate of authority issued by the Insurance Commissioner, and without meeting specified requirements for a license or certificate, provided the carrier is authorized to issue a plan or policy in the domiciliary state and complies with that state's requirements. *Failed passage in Senate Health Committee*.

SBX1 5 (Cox) would have eliminated existing allocations of tobacco tax revenue under Proposition 10 to state and local county children and families commission accounts and, instead, requires those funds to be used to provide health care services and health care initiatives, including, but not limited to, the Healthy Families Program. *Failed passage in Senate Health Committee.*

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SBX1 9 (Runner) would have directed the Department of Health Care Services (DHCS) to develop a plan for redirecting federal disproportionate share hospital program (DSH) funds, which currently are paid to public hospitals, to pay for primary care at clinics and prevents the plan's implementation until the Legislature grants specific authorization. *Failed passage in Senate Health Committee.*

SBX1 10 (Maldonado) would have conformed state law with federal law by granting a personal income tax deduction for the establishment of a health savings account (HSA). Also would conform state law to other related provisions of federal law regarding rollovers, creation of tax exempt trusts, and penalties for paying non-medical expenses. *Failed passage in Senate Health Committee.*

SBX1 21 (Cogdill) would have authorized a 25 percent credit against the net personal income tax of a medical care professional who provides medical services in a rural area for each taxable year beginning January 1, 2008. *Failed passage in Senate Health Committee.*

SBX1 23 (Ashburn) would provide an income tax credit taken against personal and corporate income taxes, equal to 15 percent of the costs related to establishing or administrating cafeteria plans, authorized under the Internal Revenue Code, that provide for the payment of health insurance premiums to employees. *Currently in Senate Revenue and Taxation Committee.*

ABX1 8 (Villines) would propose multiple strategies to address health care costs and access, including: tax incentives and government programs to promote and facilitate consumer-directed health care and employer-sponsored insurance; allowing the sale of out-of-state health insurance policies not subject to any California law or regulation; increasing Medi-Cal provider reimbursement rates and creating an income tax credit for physicians who provide unreimbursed care for the uninsured; establishing a mechanism for financial aid for training physician assistants; and, requiring benefits and assets from foundation conversions to support direct medical care. *This bill is in the Assembly Health Committee.*

***AB 2 (Dymally) and ABX1 3 (Dymally*)** would restructure the MRMIP, including eligibility, benefits, and premium rates for the program, and would require all health care service plans and disability insurers selling health insurance in the state to share in the costs of MRMIP, by either paying a fee to the state to support MRMIP costs, or by offering coverage in the individual market on a guaranteed issue basis with community rating of premiums and prior rate approval requirements. The bill requires health care service plans and health insurers in the individual insurance market to provide coverage on a guaranteed issue basis to individuals not eligible for MRMIP starting January 1, 2009. *AB 2 is currently on the Senate Inactive File. ABX1 3 is currently in Assembly Health Committee.*

AB 1554 (Jones) would require health care services plans and health insurers to receive approval from the DMHC or DOI to increase premiums, co-payments, co-insurance obligations, and deductibles. The bill would require both departments to notify the public

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of, and hold hearings on, applications from plans or insurers to increase rates. *This bill failed passage in the Senate Health Committee and was granted reconsideration.*

San Francisco Health Care Security Ordinance (2006) requires employers with 20 or more employees to spend a minimum amount per hour, per employee, on health care services, with certain exceptions. Employers could spend this amount on various health care services for its employees, including, but not limited to, health insurance, contributions to public programs for the uninsured, health savings accounts, or direct reimbursements to employees for health expenses. The Ordinance also establishes a new Health Access Program, focused on prevention services, to replace the city's current system for providing health care to the uninsured. *This ordinance was adopted by San Francisco in 2006. In December 2007, in response to a legal challenge filed by an employer group, a federal district court ruled that the ordinance's employer spending requirements violate federal ERISA law. In January 2008, a federal appellate court ruled in favor of San Francisco's request for an emergency stay, granting the City the right to implement the employer mandate while the City appeals the district court decision.*

***SB 2 (Burton and Speier, Chapter 673, Statutes of 2003*)** would have required California employers with 50 or more employees to pay a fee to the state to provide health coverage for employees or to directly provide the health coverage to employees (and dependents for larger employers). The bill would have defined minimum required coverage, and required employers to contribute at least 80 percent of the costs of coverage and employees up to 20 percent of the costs, with a cap for low-wage earners. The bill established a purchasing pool to provide coverage for employees, expanded small group market reforms to cover employers with 51-199 employees, and included a premium assistance program for individuals eligible for Medi-Cal or Healthy Families. *SB 2 was overturned in a November 2004 referendum.*

E. Arguments in support

The American Federation of State, County, and Municipal Employees (AFSCME) states that this bill would provide the largest public program expansion since the inception of Medi-Cal and Healthy Families, provide affordable, secure public insurance plans as an alternative to private insurance plans, and cover three to four million Californians through Cal-CHIPP. AFSCME also states that the bill would establish an employer minimum wage for health benefits, contain costs for the insured, protect counties and public hospitals, and provide over $1 billion in new funding for public hospitals and doctors, provide significant market reforms, including guaranteed issue, and provide affordability protections and exemptions for individuals required to buy insurance.

The California Association of Public Hospitals and Health Systems (CAPH) states that under the bill, public hospitals will receive a significant Medi-Cal rate increase which will help public hospitals maintain and improve access to care. CAPH states that it supports the expansion of coverage to childless adults, and the proposed Local Coverage Option draws upon the experience and expertise of public hospitals and community clinics. CAPH also states that the details of how the county share of cost would be

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implemented is addressed in the accompanying ballot initiative, and CAPH is prepared to accept a workable share of cost as a part of comprehensive reform.

The California Hospital Association (CHA) states that it supports comprehensive health care reform that has protections for hospitals in an accompanying initiative. CHA states that Medi-Cal is severely underfunded, with hospitals incurring over $2 billion in uncompensated care costs. CHA states that it has worked with the administration and legislative leadership to help craft a proposal that will result in more than $2 billion of new funds to hospitals annually.

The Latino Coalition for a Healthy California (LCHC) states that this bill brings meaningful health access to millions of uninsured Californians, particularly uninsured Latinos. The LCHC states that Latinos represent approximately half of the state's uninsured population, largely due to the low rate of health insurance provided by their employers. LCHC supports the bill's public coverage expansions, proposed tax credit for those without job-based coverage, and the creation of a statewide purchasing pool as a new coverage option for the uninsured.

Support if amended or with amendments

The California Public Interest Research Group (CalPIRG) states that this bill would give consumers effective tools to get a fair rate for health insurance, give all consumers access to health insurance, regardless of whether they are sick or healthy, increase the number of Californians who have useful health insurance, and contain costs. CalPIRG states that the bill's funding mechanism opens up new funding sources that would otherwise go untapped. CalPIRG proposes amendments that would clarify that all plans offered in the Cal-CHIPP pool package must meet Knox-Keene requirements, as well as providing prescription drug coverage and promoting prevention, that MRMIB has the authority to review the minimum coverage package after it is initially set, and that the tier 3 product will include first-dollar coverage for preventive care, doctor visits, and prescription drugs.

Health Access California states that it would support the bill with amendments to base premium costs on a product that provides coverage for doctor visits and prescription drugs outside of deductibles, clarify that MRMIB can review and reset minimum creditable coverage annually to take into account affordability and hardship exemptions from the previous year, clarify that the individual mandate is contingent upon employer contributions, clarify that unsubsidized benefits provided in the purchasing pool provide the same covered services as those required under Knox-Keene, as well as prescription drug coverage, and clarify that wage garnishment and liens on primary residences would require further action by the Legislature before use for enforcement of the individual mandate.

Consumers Union states that it would support the bill with amendments to clarify that enforcement of the individual mandate would not include wage garnishment and certain other features, that the unsubsidized benefits provided in the purchasing pool meet Knox-Keene requirements plus prescription drug coverage, and that the premium on which the

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tax credit will be based is for a product that provides coverage for physician visits, and prescription drugs with no deductible.

The California Labor Federation (CLF) states that it would support this bill if amended to outline the benefit standard for plans offered by the pool, including requirements to meet Knox-Keene plus prescription drugs, predicate the individual mandate upon guaranteed affordability, and the availability of quality health care coverage, clarify that the health plan to which the tax credit will be linked includes doctor visits, prescription drugs, chronic disease management, and other basic preventive services on a pre-deductible basis, clarify MRMIB's authority to grant categorical exemptions to the individual mandate in the event that granting exemptions on a case-by-case basis is not practicable, and to provide that only employer offers of coverage with employee cost-sharing arrangements at least as favorable as those in the plan to which the tax credit is benchmarked constitute an offer of coverage. CLF also proposes amendments to the proposed initiative to address concerns that the employer payroll assessment does not include a separate test for full-time and part-time employees, add penalties to enforce the employer assessment, including penalties for employers that misclassify employees as independent contractors, and make the employer assessment adjustable by a simple majority vote of the Legislature.

The Service Employees International Union (SEIU) proposes amendments to this bill that would require an annual review of the definition and standards for minimum health care coverage, as well as for affordability and hardship standards. SEIU proposes additional amendments that would clarify that the Cal-CHIPP Healthy Families plan provides the same services and benefits required by the Knox-Keene Act, plus prescription drug benefits, that prevention services include detection and management of chronic conditions, and to require all products sold in the individual market to include limits on out-of-pocket costs. SEIU also proposes amendments to the proposed initiative that would provide better information on whether employees in public programs and the purchasing pool have an accompanying employer contribution, to ensure mechanisms are in place to determine whether persons enrolled in the purchasing pool are employed, but with no employer contribution being made on their behalf, and to impose a surcharge on employers that create an unfair share of uncompensated coverage through the purchasing pool if the proportion of pool enrollees who are employed increases while employer contributions do not. Lastly, SEIU proposes amendments to require legislative action to impose wage garnishments or liens to enforce the individual mandate, make the individual mandate contingent upon employer contributions, add provisions to minimize the misclassification of employees as independent contractors, and provisions to address potential conflict of interest among members and staff of MRMIB.

The Western Center on Law and Poverty (WCLP) proposes a number of amendments to this bill, and states that the bill limits pool coverage options for low-income, childless adults by imposing an employer firewall standard that requires they not be offered employer-sponsored health care coverage. WCLP states that under this requirement, childless adults with incomes at or below 100 percent of the FPL who could not afford their employer-based coverage, or who have a meager employer contribution toward health care coverage, would be barred from obtaining coverage under this bill. WCLP

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asserts that this bill would allow MRMIB to determine processes and benefits for Medi-Cal enrollees, such as those in the Cal-CHIPP Healthy Families plan, and recommends stakeholder input and legislative oversight so that MRMIB does not have unfettered authority to make decisions affecting this population that would be better made by the Legislature or other entities. WCLP also states that while the bill would require pool enrollees to appeal decisions regarding eligibility, enrollment, and coverage to MRMIB, certain enrollees, such as those in the Medi-Cal population, would have due process rights under existing law. WCLP proposes that DHCS, in consultation with MRMIB and a stakeholder group, work through the issues that overlap, and implement appeals processes through subsequent legislation.

Kaiser Permanente (KP) states that, if broad categories of exemptions to the individual mandate are implemented, premiums for those who are among the most vulnerable, namely those in the individual market, will dramatically increase. KP states that those who are less healthy will seek coverage, while those who are healthy will be free to seek exemptions from the mandate. KP states that, while the bill attempts to prevent adverse selection through state subsidies to normalize the market, the funding for these subsidies is not mandatory. KP argues that the funding should be automatic in order to protect access to coverage. KP also seeks an amendment regarding the proposed health plan assessment to fund a reinsurance mechanism for plans in the individual market. KP states that the bill does not specify that any assessment must include all covered lives in order to be equitable, and if self-funded arrangements are excluded from the assessment, their purchasers would disproportionately shoulder the burden of the reinsurance mechanism.

The California Federation of Teachers (CFT) states that it would support the bill if amended to define minimum creditable coverage, make clear that county hospitals will maintain current services to those who need it, and address how the affordability threshold would apply to individuals who might lose a job, or find themselves unemployed for over a year. The CFT proposes amendments that would impose rate regulation that will not allow insurers to exorbitantly raise rates without justification, create a mechanism to increase employer contributions and require that they be calculated separately for low-income and middle- to upper-income employee units, provide for an adjustment of the affordability threshold downward if employer contributions decrease, and define “affordable” coverage based on total out-of-pocket costs, not just premiums. The CFT also states that it cannot wholeheartedly support the bill, because it is uncertain if the financing provisions will be adopted by the voters.

The Having Our Say (HOS) coalition supports the bill’s proposed public coverage expansions, community makeover grants, and clinic reimbursement provisions. HOS states that it continues to oppose an individual mandate, as there is no guarantee affordable coverage will be available. HOS states that minimum creditable coverage remains undefined in the bill, and expresses concerns that communities of color may be required to purchase coverage that does not provide needed health care services. HOS asserts that minimum creditable coverage should meet Knox-Keene requirements plus prescription drugs. HOS also states that it is unclear how various working and immigrant communities will have access to the purchasing pool, and how all workers, including

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seasonal, part-time and temporary workers will be treated equally. HOS proposes that the 5 percent premium cap for pool enrollees with an income at or below 250 percent of the FPL be inclusive of all out-of-pocket expenses, not just premiums.

Concerns

The County of San Diego (County) states that it is unclear how the proposed fiscal benefits to the counties will be accomplished, and that the diversion of funds from existing programs would have a negative impact on its ability to provide existing services. The County states that the mandate for counties and public authorities to contribute towards benefits for all IHSS providers and dependents is cost prohibitive, and the bill's requirements that counties provide benefits through a mandated union trust would remove local government flexibility, accountability, and control over how taxpayer dollars are managed and spent. The County asserts that the definition of "employer provided" in the proposed initiative would require the County to provide health care contributions for a significantly larger population, including election workers and temporary professionals, thereby imposing substantially greater fiscal obligations. Additionally, the County argues that under the proposed initiative's severability provisions, if any provision is found to be invalid or unconstitutional, the remaining provisions would be unaffected. The County argues that under this type of structure, the employer contribution could be deemed unconstitutional, whereas, the county share-of-cost provisions could remain, and be increased to make up for financing shortfalls.

The California Medical Association (CMA) states that, it is concerned the proposed financing for the bill will not fully fund all of its provisions, particularly those that would ensure access to affordable coverage through the pool. CMA states that the bill proposes to expand Medi-Cal eligibility, but does not make important changes to improve the program, such as increasing Medi-Cal rates which, although provided for in the bill, is contingent upon a budget appropriation. CMA asserts that the bill contains several provisions that appear to erode oversight of insurers, including those that allow a Medi-Cal managed care HMO to be "deemed" compliant with state filing and reporting requirements, and that eliminate HMO reporting on enrollee grievances and making arbitration decisions unavailable to consumers. CMA states that under the bill, health plans would have flexibility in establishing provider networks that could be inadequate and limit access to care, and that medical loss ratio provisions are not strong enough in that they allow an aggregate calculation by averaging all of their licensed products, and potentially categorize business costs as the provision of health care benefits. CMA states that the bill's scope of practice language is vague as to whether the allied health care professionals may supervise medical assistants independent of physician supervision, and that they are concerned about HHS and PERS having broad discretion over a pay-for-performance program, which encourages providers to shift focus from treating the particular needs of the patient, to meeting inflexible performance measures. CMA argues that the provider outcome measures providers should be developed by clinicians and experts rather than a committee of political appointees with no legislative oversight, and that creating a new bureaucracy and requiring new data reporting will increase system costs, especially in light of the fact that an abundant amount of data currently is available. Lastly, CMA states that the bill would require electronic prescribing to comply with

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national standards, but does not define those standards, and that the provisions to require prescribers to offer a written receipt undermines the purpose of an e-prescribing system.

The California Association of Health Underwriters (CAHU) and the National Association of Insurance and Financial Advisors – California (NAIFA-California) proposes amendments to address concerns relating to medical loss ratios and adverse risk selection in the individual market. The organizations state that individuals receiving premium assistance in the form of tax credits should not be segregated into the state purchasing pool, with limited benefit choices and higher premiums, and should be afforded flexibility to obtain coverage inside or outside of the pool. The organizations state that minimum creditable coverage should be defined in the bill, and that it is impossible to assess the cost impact of the bill without such a definition. The organizations argue that the bill fails to provide meaningful criteria for MRMIB to use when determining exemptions to the individual mandate, which could result in adverse selection in the individual market. Lastly, they state that funding for the bill is precarious, as medical costs have risen at twice the rate of wage growth for the past 20 years.

Blue Shield of California states that it supports the bill's general framework, but has concerns with the bill's exemptions from the individual mandate which could result in a significant number of people waiting until they need expensive medical care before they can purchase health coverage. Blue Shield states that this would raise premiums for those who buy coverage in the individual market. Blue Shield also states that the bill contains provisions that create a reinsurance safety valve if the risk in the individual market exceeds the risk of a normalized market, but that the proposed initiative does not adequately describe the scope of the proposed insurer fee or assure funding of the reinsurance safety valve.

Project Inform and the San Francisco AIDS Foundation (SFAF) state that, under the bill, many people with HIV/AIDS who currently have access to free, quality health care would be required to pay premiums and other cost-sharing burdens, and asserts that the bill's intent language to use federal Ryan White funds to offset cost-sharing burdens will not sufficiently protect people with HIV/AIDS from a disruption of care and/or treatment as they transition from their current coverage to a new system. The organizations also propose provisions that would delay the inclusion of people with HIV/AIDS from the individual mandate for up to one year in order to allow this vulnerable population a transition period to minimize negative health impacts.

F. Arguments in opposition

Blue Cross of California (BCC) states that the bill's provisions for guaranteed issue and modified community rating would destabilize the individual market, as it requires members of the individual market to subsidize the cost of insuring those that do not currently qualify for coverage. BCC asserts that modified community rating eliminates an insurer's ability to provide discounts to healthier individuals, resulting in younger and healthier enrollees dropping individual coverage, which would increase costs for other enrollees. Blue Cross states that the five coverage choice categories proposed by the bill would likely require maternity benefits and a name-brand drug benefit, which would

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significantly increase premiums, and impact hundreds of thousands of Blue Cross enrollees who pay for affordable products which do not offer such benefits. BCC argues that consumers should drive decisions to define what insurance products are acceptable in order to decrease consumer costs, increase consumer satisfaction, and decrease the number of the uninsured. BCC asserts that the proposed individual mandate lacks enforceability, provides no penalties for failure to comply, and provides exemptions that would result in adverse selection. BCC argues that medical loss ratio requirements, such as the one proposed by this bill, increase premiums, reduce consumer choice, increase the number of uninsured, and reduce quality, because they discourage insurers from spending on administration, many components of which benefit consumers and control costs, from developing low-cost products, and from participating in high cost markets. BCC contends that the projected fiscal assumptions based on $224 per-member, per-month (PMPM) premium cost for products offered through the pool are understated as average group premiums for single adult coverage are much higher ($379 PMPM in 2006), and continue to rise.

The California Nurses Association (CNA) states that, under this bill, health insurance will not be universal, affordable, or of high quality, and bare bones plans with high out-of-pocket costs will be forced upon Californians and employers who will have no control over the price. CNA states that this bill implements a punitive individual mandate, that the FTB will use its civil power to collect funds through wage garnishments and mortgage liens, and that because of its severability provisions, the individual mandate could continue to be implemented without any requirements on employers. CNA argues that the bill does not guarantee affordable, quality health care for all Californians, and that, without cost limits for premiums and other out-of-pocket costs, it does not control health care costs without further eroding necessary health care. CNA contends that the bill does not fairly distribute responsibility, risk, and benefits among employees, employers, and individuals, as health care costs are further shifted to workers, individuals, and government, while insurance companies and employers have the lion's share of benefits from the bill. CNA states that the bill does not guarantee patient choice of provider or hospital, does not protect the doctor-patient relationship, does not improve quality of care and patient outcomes, and does not protect the public hospital safety net. CNA states that the bill's scope of practice provisions will create conditions for an increase in medical errors, healthcare acquired infections, malpractice law suits, and adverse events, rather than protecting the public. CNA writes that MAs should only work under close supervision and only in organized health care systems or licensed facilities and that the employment of medical assistants elsewhere poses risks to the public's health and safety. CNA also argues that the bill's provisions establishing a NP taskforce should be deleted as it sets up a bureaucratic and duplicative system that is costly to the state, and not authorized by existing statute.

Various labor organizations, including the California Teamsters, the United Food and Commercial Workers Union, the Engineers and Scientists of California, Local 20, and the California Conference of Machinists, state that this bill fails to obligate employers to pay a percentage of health care costs for both high- and low-wage workers. As a result, an employer could meet statutory obligations without paying anything toward low-wage workers, and instead, place the low-wage workers into the state purchasing pool,

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requiring taxpayers to subsidize the cost. The organizations state that the bill requires individuals to purchase health care without any guarantee of affordability, and does not contain an employer definition or associated penalties which would serve as a disincentive for employers to misclassify their employees as independent contractors. The organizations also state that it would be imprudent to expand costs to the state by implementing health care reform until such time as the state had addressed the budget deficit.

The Foundation for Taxpayer and Consumer Rights (FTCR) opposes the bill's individual mandate to maintain minimum coverage, and states that the solution to the state's health care crisis is not to require Californians to buy private insurance policies they cannot afford and that provide no guarantee of coverage. FTCR argues that the bill does not provide caps on premiums, maximums on deductibles, or floors on benefits to protect consumers from being forced to buy bare-bones insurance they cannot afford to use when they fall ill. FTCR states that, under the mandate exemption provided for in the bill, many patients will be left uninsured, and that the process by which the state would make individual exemption determinations would be lengthy and costly. FTCR argues that the medical loss ratio provisions, absent regulation of premiums and out-of-pocket costs, would increase rates as insurers would have incentives to increase provider payments, and charge more in order to keep more. FTCR states that the maximum 6.5 percent employer contribution is approximately half of what many employers spend today, and that employees who are currently covered through their employer may end up with pool coverage that offers fewer benefits at a higher cost. FTCR also asserts that the proposed tax credit is insufficient to help individuals cover the cost of purchasing their own insurance, and the insufficiency would worsen each year as the tax credit would adjust only to the overall rate of inflation, while insurance premiums rise two to three times faster than inflation.

The California School Employees Association (CSEA) states that under the current proposal, employers would not be required to cover part-time workers, and could provide benefits only to management or full-time employees as long as total spending meets the minimum employer contribution. CSEA argues that under this type of structure, many low-wage workers will receive little or no employer contribution toward health care. CSEA also states that if employers make nominal health care contributions, employees who would be otherwise eligible for access to the pool and subsidies would be denied both. CSEA states that the bill does not specify the minimum level of coverage, nor the cost of the benefit, thereby offering no assurance that it will be affordable or provide adequate coverage. CSEA argues that the bill does not adequately address the rising cost of insurance, which is the most pressing issue for classified employees and other working people.

Various business organizations, including CalChamber, the California Restaurant Association, National Federation of Independent Business, and the California Manufacturing and Technology Association, state that the bill's provisions anticipate revenue that will likely be inadequate for the programs proposed, and if a determination is made that funding is inadequate, some of the programs, most notably the purchasing pool, would be suspended, leaving many without coverage. The organizations also state

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that many Californians, including the self-employed, rely on affordable individual policies for their health coverage, and that this bill would impose substantial premium increases on these individuals by providing for guaranteed issue and community rating without enforcement of the individual mandate. The organizations also argue that the bill undermines the intent and spirit of ERISA.

The Howard Jarvis Taxpayer Association (HJTA) states that placing a four percent fee against aggregate hospital revenue will decrease access to care, and questions the logic of a tobacco tax increase given that a similar measure failed on last year's ballot. The HJTA opposes the inclusion of an individual mandate, as decisions to receive health care should rest on individuals, not the government. The HJTA asserts that many aspects of the bill violate state and federal law, including the imposition of a tax increase on employers without a two-thirds vote, as well as employer contribution requirements which would violate ERISA. Lastly, the HJTA opposes provisions to provide coverage for all children, including those of illegal immigrants, to receive health care given the state's budget deficit.

Oppose unless amended

Protection and Advocacy, Inc. (PAI) proposes amendments to the bill that would address concerns regarding access to care, and affordability, including recognition of the additional financial health care burdens carried by people with disabilities which limit their ability to afford the premiums required by this legislation. PAI also states that the scope of benefits should include essential items such as durable medical equipment. PAI notes that a lack of coverage of items and equipment used only by people with disabilities increases the cost of care solely for people with disabilities.

The California Association of Public Authorities for IHSS (CAPA) states that this bill would hamper county and public authority's ability to ensure the provision of timely, appropriate and cost-effective IHSS services to those most in need. CAPA states that the bill contradicts the language and the intent of the legislation that created public authorities, and that it would eliminate the power of public authorities to act as the employer of IHSS providers in negotiating benefits as a term and condition of employment. CAPA also objects to the bills provisions mandating the use of a union health care trust to provide benefits, as they will drive up costs and inhibit the public authorities' ability to ensure quality.

POSITIONS

Support: 100% Campaign
AARP
Alzheimer's Association (with amendments)
American Federation of State, County, and Municipal Employees
American Cancer Society, California Division
Blue Shield of California
California Academy of Family Physicians (if amended)

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California Association for Nurse Practitioners
California Association of Physician Groups
California Association of Public Hospitals and Health Systems
California Catholic Conference
California Children's Hospital Association
California Chronic Care Coalition
California Conference of Carpenters
California Congress of Seniors
California Federation of Teachers (if amended)
California Hospital Association
California Immigrant Policy Center (if amended)
California Labor Federation (if amended)
California Pan-Ethnic Health Network (if amended)
California Primary Care Association
California Public Interest Research Group
California State Conference of the NAACP
California State Council of Laborers
California State Pipe Trades Council
Catholic Healthcare West
Children's Health Initiative of Greater Los Angeles
Children's Health Initiative of Napa County
Coalition to Advance Healthcare Reform
Community Health Councils
Congress of California Seniors
Consumers Union (with amendments)
County of Los Angeles
County of Santa Cruz Health Services Agency
Having Our Say (if amended)
Health Access California (with amendments)
Insure the Uninsured Project
JERICHO (if amended)
Kaiser Permanente (if amended)
LA Health Action (with amendments)
Latino Coalition for a Healthy California
Latino Issues Forum
Los Angeles County Department of Health Services (with amendments)
Marin Institute (if amended)
Molina Healthcare (if amended)
National Association of Women Business Owners – Los Angeles Chapter
Northeast Valley Health Corporation
Osteopathic Physicians and Surgeons of California (if amended)
PICO California
Planned Parenthood Affiliates of California
Santa Clara Family Health Plan
Service Employees International Union (with amendments)
Service Employees International Union United Long Term Care Workers' Union

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Silicon Valley Leadership Group
Small Business Majority
State Association of Electrical Workers
Union of American Physicians & Dentists
United Domestic Workers of America
United Farm Workers
United Way of Santa Cruz County
Unitarian Universalist Legislative Ministry Action Network (with amendments)
Valley Community Clinic
Western Center on Law and Poverty (if amended)
Approximately 700 individuals

Oppose: Applied Research Center
Blue Cross of California
CalChamber
Cal-Tax
California Alliance for Retired Americans
California Association of Public Authorities (unless amended)
California Business Properties Associations
California Business Roundtable
California Church IMPACT
California Conference of Machinists
California Hotel and Lodging Association
California Manufacturers and Technology Association
California Motor Car Dealers Association
California Nurses Association
California Physicians Alliance
California Retailers Association
California Restaurant Association
California School Employees Association
California Teamsters Public Affairs Council
Consulting Engineers and Land Surveyors of California
Democratic Club of Coarsegold
Democratic Party of Lake County
Engineers and Scientists of California, IFPTE Local 20
Foundation for Taxpayer and Consumer Rights
Friends Committee on Legislation of California
Gray Panthers
Howard Jarvis Taxpayers Association
IBA West
International Longshore and Warehouse Union
Joint Council of Teamsters, No. 38
Lambda Letters Project
League of Women Voters
National Federation of Independent Business
Philip Morris USA

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Protection and Advocacy Inc. (unless amended)
Siebens Patient Care Communications
United Food and Commercial Workers Union
Approximately 350 individuals

- END –

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